May 1959

Mental Hospitals

Official Hospital Journal of
American Psychiatric Association

"Humane treatment may raise up one in whom the divine image has long been obscured. It is with the unfortunate, above all, that humane conduct is necessary."

FEDOR DOSTOEVSKI (1821-1881)

Mental Hospitals

VOLUME 10 NUMBER 5

Editor: Mathew Ross, M.D.

Chief, Editorial Dept.: Pat Vosburgh

Editorial Assistant: Mary M. Thomson

Production Assistant: M. E. Pace

Editorial Researcher: Lucette G. Nagourny

Advertising & Promotion: Phyllis Woodward, LL.B.

National Advertising Representative:
Fred C. Michalove, 6 East 39th Street,
New York 16, N.Y. (MUrray Hill 5-6332)

Published monthly, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Subscription price: At the rate of $6.50 a year each, up to 44 copies of each issue are included in the dues, which range from $50 to $350 a year for institutional subscribers, based on the number of beds in an institution. Individual subscription rate (for staff members of subscribing institutions only) $6.50 a year. Limited Service subscriptions of $25 a year for related professional organizations and mental hygiene societies include 5 copies of each issue. Published by the American Psychiatric Association Mental Hospital Service, 1700 18th Street, N.W., Washington, D.C. Second class postage paid at Washington, D.C.

OFFICIAL HOSPITAL JOURNAL OF
AMERICAN PSYCHIATRIC ASSOCIATION

CONTENTS, MAY 1959

NEW AIRKEM PROGRAM
A HEALTHIER ENVIRONMENT

Are you satisfied with the sanitation maintenance program in your hospital? New Airkem program assures maximum protection against cross-infection, provides thoroughly clean surfaces and guarantees an odor-free atmosphere with an air-freshened effect.

PLAN NOW TO PROTECT HOSPITAL STANDARDS OF CLEANLINESS BY USING SIMPLE, ECONOMICAL PROCEDURES

It is a known fact that control of cross-infection in the hospital requires an understanding of modern cleaning techniques by the cleaning staff. To assure maximum protection for your patients and staff it is imperative that your cleaning program provide maximum sanitation of walls, floors and other surfaces including toilet facilities. Airkem techniques give this protection. In addition, the multiple action characteristics of Airkem products reduce the danger of accidental omission of certain stages of hospital cleaning operations.

Airkem's specialized odor counteractants reduce malodorous conditions which are frequently offensive to patients, staff and visitors. Airkem odor control equipment assures constant protection in every area of the hospital, makes possible full use of beds adjacent to severely malodorous conditions. Airkem techniques are effective against kitchen odors, in laboratories, in wards and in special applications against incontinence and vomitus.

Cleaning Has A New Dimension
Soil removal and disinfection are on
two phases of complete sanitatio
There's a third vital dimension—od
control. Only Airkem A-3 gives you
three because it is the only multi-pu
pose cleaner that contains a true od
counteractant. This balanced non-ion
synthetic detergent removes soil, dis
fects washed surfaces, controls od
and adds an air-freshened effect—all
one labor-saving operation.

PROFESSIONAL Feature Of The Month

Management of the Geriatric Mentally Retarded Patient

By

H. V. BAIR, M.D., *Superintendent*

and

H. LELAND, Ph.D., *Director, Clinical Psychology*

Parsons State Hospital and Training Center

Parsons, Kansas

PROBLEMS associated with the direct care of the geriatric, mentally retarded patient are constantly recurring ones for state hospital management. There is an urgent need today for positive action to solve the larger problem created by the presence of a geriatric population in institutions engaged in activity-centered programs geared to modern concepts of treatment for the mentally handicapped.

Most geriatric patients now in institutions for the retarded were placed there as children. The influences and attitudes of society outside the institution, and the almost complete lack of therapeutic activity within, combined to keep them from contact with the outside world and to make them the senile, regressed, institutionalized, custodial-type patients under discussion here. Present-day knowledge indicates that many may not originally have been proper candidates for such institutions, and that admission in some cases may have been based on situations involving juvenile delinquency or illegitimacy rather than lack of mental ability. Undoubtedly many were children whose problems stemmed from emotional disorders, but because the concept of childhood schizophrenia was either unknown or unacceptable, they were diagnosed as "idiotic" or "feeble-minded," to use the terms popular in that day. Whatever the reason given by admitting authorities, once inside the institution the patients received little more than custodial care.

New Life in Programs for the Retarded

In the last decade new concepts have guided programming for the retarded; modern treatment and training centers have replaced custodial homes; medical science has developed new drugs to help the aged withstand serious physical maladies. To meet the challenge of progress in these areas, institutions are developing new staff and improving staff consciousness of patient needs. Disciplines not previously concerned with the question of mental retardation are now actively involved; younger men and women are entering the field and generally there is new movement, new life, more interest and activity. These new people, with stimulating ideas to apply in their chosen field of service, find they have inherited a large population of patients who have grown old in the institution. These patients have lived so long with only the custodial care of less progressive days that they are not amenable to the treatment procedures prescribed for mentally retarded children and young people. The superintendent is reluctant to admit that he has a custodial population on his hands, but eventually he must accept the fact that the usual techniques are not productive with his aged patients.

Geriatric Population Sits or Wanders

It does not take the new staff long to recognize that most of the geriatric population fits into one of two categories—those who sit and those who wander. The "sitters" have a routine consisting of getting up in the morning, caring for their needs or having them cared for, and moving to a chair in the day room. There they remain until lunch time. The same routine is followed after lunch, uninterrupted except to eat and retire for the night. The wanderer, on the other hand, never sits down, once his personal needs are cared for. In the "locked" institution he will be found pacing the day room from wall to wall and back again. If he is in an "open" institution he will be allowed on the grounds to walk all day, with no destination in mind, but fulfilling his need to keep moving.

Close examination brings individuality to these patients. It becomes apparent to the observer that assign-

ment to the geriatric ward is not necessarily based on chronological old age, but often on evidence of the various symptoms of senescence. Many such patients are only 40 to 50 years old. Outside the institution they would not be senile, and as private hospital patients they would not be termed geriatric. In the institutional setting, however, their behavior and management needs fit the pattern consistent with that of much older persons.

Rapid Aging Possible Result of Long Confinement

This process of rapid aging is not an unavoidable consequence of mental retardation. It is more apt to be the result of institutionalization over a long period of time in a non-challenging, non-demanding milieu. There is some evidence that the same aging process takes place in children who spend any length of time in an institution without the stimulation of proper treatment and training to make one day different from another. A complete absence of therapeutic activity is probably more lastingly harmful to the patient who was actually psychotic as a child but received no treatment for the condition. Such patients become "burned out" during long years of incarceration; the few inner resources they once had disappear, and they become totally dependent on the institution and the unchanging schedule it maintains. They may be able to develop a relationship but this is rare and usually to a specific aide to whom the patient relates as in a child-parent situation. Group identities will develop in this portion of the population, but sex problems seldom occur, nor behavior problems, although a patient may "blow up" occasionally. The physical appearance of the group resembles that of a geriatric population anywhere, with one important exception—the chronological age is much lower, the average being approximately 40 years, not 50, 60 or 70 as is ordinarily true of a geriatric population.

Some senile, withdrawn patients pose no great man agement difficulty and it seems logical to question the feasibility of keeping them in an institution. Except for a minimum amount of management, no demands would be made on society if they were to be discharged to a sheltered environment in the community. It is entirely possible that some of these patients could provide for their own needs and even perform useful work if they could be placed in a semi-sheltered setting where they would not have to cope with too many problems in an unfamiliar world. Still others could benefit from an organized rehabilitation program. Many such men and women are now being utilized as institutional workers and in some instances whole sections of an institution are operated by patients who could be drawing wages for their labor if a living situation could be found for them in the community.

Patient Labor Camouflaged as Rehabilitation

The practice of using patient labor is common in public institutions and many administrators estimate their annual budget in terms of the amount of labor performed by these unpaid workers. In some areas attempts are made to disguise the practice by employing such terms as "vocational rehabilitation" and "job training" when speaking of the patients' contribution; however, inasmuch as many such workers are too old to be candidates for complete discharge, the terms appear deceptive and are probably used only to describe work without pay in a manner acceptable in a rehabilitation setting.

A geriatric population, then, appears to consist of three groups: one, those patients incapable of managing their own needs; two, those who can do a great deal for themselves, but because of advanced age are not considered for discharge although continuing as part of the institutional work force; and three, those who, although at a lower chronological age, have the symptoms of old age and are treated as geriatrics.

Standard I.Q. and mental level classifications cannot be applied to the three categories of patients when considering their potential. The institutional worker may have an I.Q. of 30 and the unproductive "sitters" and "wanderers" may include individuals with I.Q.'s in the 70's. Differences in behavior result to some extent from the reason for institutionalization in the beginning, but to an even greater extent from the type and variety of experiences offered the patient, or, as the case may be, the complete lack of experiences.

Supervised Living Situations Offer Solution

What is the future for these patients? We know that many, and certainly those now being used as institutional workers, could lead a life of some productiveness outside the institution. Obviously they cannot be turned out to face the world alone after spending most of their life in an institution. Even uncomplicated, day-to-day planning would involve decisions they have never had to make, and this would prove to be such a challenging and traumatic experience that the patient would undoubtedly be returned to the institution or, more likely, land in the nearest psychiatric ward. The solution to this problem lies in providing supervised living situations, probably a half-way-house type of environment where institutional ties would not be cut immediately and the damaging effect of abrupt change would not add to the problems inherent in even partial independence.

Although job opportunities for the retarded are fewer than in former years, particularly in agriculture, means for making a living in the community could be made available. Domestic work, gardening, institutional chores and janitorial services are some of the jobs that the retarded adult can perform, and most have been trained in these areas before they leave the institution. Such work is normally supervised, whether or not the worker is retarded; consequently a controlled environment is provided as a matter of course. If the community accepts the patient after he becomes established in the sheltered workshop or in the supervised job setting, his spare time can be spent much like that of other senior citizens in the area. Of course, society must develop a sense of responsibility in this respect or the patient will never realize his full potential as a productive and useful member of the community.

Turning from the active, potentially productive, geriatric patients to the "sitters" of the institutional population, the claim can be made that it matters little where their inactivity takes place—the "sitter" could just as

readily sit in a nursing home as in a hospital. This attitude may seem perfunctory, but it must be remembered that this type of patient cares not where his idle time is spent; on the other hand, it is of vital importance to hospital management because the space occupied by the "sitter" in the institution is at a premium.

Many Youngsters Waiting for Treatment

Hundreds of children are waiting for the help that institutions are able and eager to give while the recipients are young and potentially capable of absorbing the treatment and training procedures designed for them. The professional skill and clinical facilities of an institution dedicated to treatment and rehabilitation should not be used without purpose, for thus we undermine the very program goals set in response to the need and demand for such services. But only when the family and community at large accept part of the responsibility for care of elderly patients will the long lists of children awaiting admission to institutions be reduced and the true purpose of dynamic programs for the retarded be realized.

The problem of placing the "wanderers" of the geriatric population is slightly more complex because many nursing homes are located in heavy traffic areas and the patient, unless closely supervised or constantly restricted, would find himself in difficult and even dangerous situations. The nursing home, or "old folks home," cannot be expected to provide the control available in an institution and there is the possibility of the patient's being harmed, or of harming himself. The answer here is to make available in the community a hospital-type home for the "wanderers." It is almost impossible to differentiate between the type of patient under discussion and the senile psychotic or cerebral arteriosclerotic patient in most of our adult mental hospitals. With such gross similarity in the two types, it would seem that a single facility caring for all would meet the needs of both kinds of institutions and thus release bed space for younger, more responsive patients. However, this is another question deserving of special approach.

Institutions Not Now Geared to Geriatric Patients

The viewpoint presented here is, of course, related to the present status quo of the public institution. It is not our intent to imply that patients here recommended for placement in nursing homes or other community facilities could not be helped to some extent. The "sitters" might get up and the "wanderers" might settle down. But solution of the problem within the institution would require action few are prepared to take. Additional staff would be necessary, and if acquired, would have to be trained to know the process of aging and how to develop programs specifically for the geriatric population, rather than attempt to adapt established programs to fit particular needs. Present personnel are not equipped to deal with such problems and when they are faced with programming for the older patient, their first thought is of "busy work" such as arts and crafts activities, or some limited recreation projects. If new staff were available it would be feasible to consider as candidates for rehabilitation on a limited scale those patients who are now merely management problems. The major obstacle is how to devote effort to such an end when the needs of children and youth are so great. This should not reflect a neglect of our older population, nor should it indicate a lack of humanism. Conditions today merely bring to light some unfortunate practicalities of our institutional situations. Certainly it would be worthwhile to exert more effort for the geriatric patient. Where such programming has been tried results have been favorable, particularly in regard to returning the patient to his home community under circumstances that permit an adequate level of functioning. Also, it has been noted that many prematurely aged patients become younger, in a sense, if placed in a program with emphasis on rehabilitation. Such patients have even been known to react as expected of persons in their chronological age group; unfortunately, this is not a result to be expected; such patients usually have signs of senile atrophy of the cells, tissues, organs and organic systems. However, this fact need not be a deterrent in approaching the patient as if he were actually younger, for through this approach a more productive program might evolve. In fact, from the rehabilitation point of view, at least with the mentally retarded, the key would seem to be the assumption that such patients are capable of better response than has been indicated, rather than the opposite attitude that the time has passed when any therapy would be of benefit. As a rehabilitative agency, our function should be to strengthen those areas that are valid and consistent with normal intellectual performance, and adapt them to activities for the geriatric patient who is retarded. We contend that most of the services for geriatric individuals in the community could also be utilized beneficially for the retarded geriatric in institutions. In other words, concern for the problems of management should give way to emphasis on how much of the individual can be salvaged.

To return to the question of premature aging in the institutional population, it appears that a tremendous preventive job could be done by rehabilitation teams in this field. It may be (and this proposition should be a real challenge to researchers) that the brain damage or organic disability factors that produced or led to the original mental retardation may also lead to more rapid degeneration of the whole body. No theory is intended regarding this possibility but nevertheless the statement can be unequivocally made that patients in institutions for the mentally retarded tend to age more rapidly than other individuals.

Five-Point Program Suggested

A five-point program for geriatric patients in institutions dealing primarily with the mentally retarded would seem to be in order: (1) those patients with a capability for productiveness and an ability to care for themselves should be discharged to the community and allowed to become useful citizens in supervised settings; (2) those patients who are able to care for themselves but are incapable of productive work should be transferred to some type of county home where they can live out their remaining years in "freedom" among individuals of like age and ability; (3) those individuals who present management problems in the area of self-care but whose

behavior is acceptable can be sent to nursing homes or returned to their families and receive the same level of care now provided in the institution; (4) those who present serious management problems and whose behavior evokes the possibility of danger to themselves and others must remain in a hospital or institutional setting, but one designed specifically for senile patients should be provided; (5) finally, institutional programs should be reviewed for possible methods of preventing premature senility as well as ways to help the normally senile to care for themselves at a higher level and thus reduce the rapid rate of deterioration currently prevalent in institutions.

Special Staff and New Programming Needed

Special staff and new programming should be developed to provide intensive treatment for the aged patient so that as many lives as possible can be salvaged from the scrap heap called the "geriatric custodials." Such measures would not only satisfy our sense of practicality by making much-needed bed space available for waiting children but also help society to take a step forward by recognizing the needs of the aged retarded, a segment of our population almost completely forgotten in the rehabilitation "push" of recent years.

Significant Issue Is How Well Patients Function

It will be noted that the problems herein discussed have not been attributed to the condition of mental retardation, as is so often done. The reason for this is valid—namely, a lack of mental ability should not be the primary factor in considering plans for patients of advanced age and deterioration. Their retardation should be judged in exact proportion to the importance placed on the mental condition of other deteriorated older citizens. The only issue of significance should be how much the patient can do for himself and how well he can function in an outside community. It must be remembered that years ago large numbers of geriatric patients were improperly admitted to institutions for the retarded when radically different standards existed for judging competence. Thus the primary consideration, and perhaps the only one, should be care of the whole geriatric population, regardless of mental level.

The Pen Is Mightier

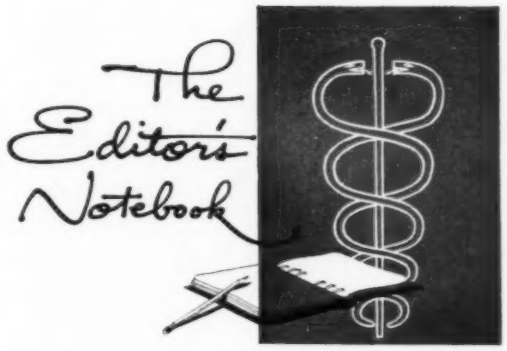
By DR. WHATSISNAME

In the army, physicians are the only professional group which needs an "administrative" corps. Engineers, attorneys, artillerymen, and signal officers, all do their own administering. But we doctors complain that "paper work" is beneath us. We are so busy succoring lives that we cannot take time to fill out forms. So the Army gives us a corps of administrators to do that. In hospitals too, we often delegate duties to non-physicians on the theory that doctors' time is too valuable for administrative chores.

But this is becoming more and more a paper world. Charts, forms, records, and certificates now bound our lives. You cannot get a patient in or out without paper work. You cannot buy a pencil or requisition a mop without filling out a form. You cannot get funds without preparing a report, a budget and a supporting document. Your right to keep a patient or his right to be released is expressed through a printed paper. With Blue Cross, commercial insurance, Veterans Administration authorizations, retirement system and pension reimbursement, with all that, you must fill out forms to collect bills.

The flow of paper will never abate. Records are larger and holier than ever before. Whenever there is a change, it is always in the direction of converting an informal procedure into a documented one. Before long, the most vulnerable spot in a hospital will be its paper supply shelf.

On the theory of joining 'em if you can't lick 'em, the perspicacious doctor shrugs his shoulders, fills his pen and goes to work. There are always little helpers who are willing to unravel the red tape for the physician. But in a world that is tied up with red tape, power goes to those who can handle the paper work. It is a pretty dream, that of the physician sweating away at the relief of suffering, too busy to read documents or fill out forms. But in the modern hospital, the pen is mightier than the scalpel. He who controls the paper work is in the driver's seat.



BY THE TIME this issue of MENTAL HOSPITALS is published, I shall have lived through my first A.P.A. Annual Meeting as Medical Director, as well as my first Mental Hospital Institute. The tolerance, understanding and patience which the officers, fellows and members have extended to me during these first months have given me strength when it has sometimes seemed that (this quote is by courtesy of Dr. Francis Braceland and Lewis Carroll) "It takes all the running you can do to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that."

Our lead article "Management of the Geriatric Mentally Retarded Patient" by Dr. Bair (Page 9) is one of a short series on various aspects of geriatric care, being published prior to the Eleventh Mental Hospital Institute, to stimulate thinking and arouse interest in our main discussion topic "The Psychiatric Problems of the Aging and of the Aging Mental Defective." Additional contributions are welcome—only send them *early* please!

This month the Midwest is especially well represented in the magazine. Often we hear the complaint that our friends out there feel isolated from us here in Washington, D. C., and it says much for their good will that they continue to send us such excellent material. I plan a mid-western trip in the not-too-distant future to see at first hand some of the outstanding programs.

Mental deficiency is also strongly accented—all three contributors have excellent programs for these patients. This month's cover quotation seems singularly appropriate to the mentally retarded and to the aging patient. Both have been too long overlooked and neglected in our hospital programs.

I think you'll agree that the overseas letters in READERS' FORUM are especially interesting. We think we have troubles! If anyone feels he can be helpful to Drs. Ro Chae-Song or Osamu Kan, please send letters or material to me and I will gladly forward it. Let's share our riches, such as they are.

I get many letters from people in the underdeveloped countries, pleading for help, and this leads me to ask, "What becomes of the psychiatric libraries of deceased members?" If families would donate books to the A.P.A., we could put items of historical value into the permanent library in Washington and ship the others abroad to needy medical schools and training centers. Do you know of any families we might approach about this?

Dr. Tillim's letter (Page 42), somewhat condensed, compels me to challenge some of his statements, *but not his right to make them!* Psychiatry is only too aware of its limitations and the responsible among us—an overwhelming majority—realize full well the importance of enlightened, dynamic leadership. I cannot agree with Dr. Tillim that we are giving aid and comfort to unqualified people. Our primary job is with the sick, but anything we can do in the way of prevention, by means of sound medical leadership, must not be withheld. It behooves us to work with our medical colleagues and with appropriate agencies, and this we are doing. If sometimes the "lunatic fringe" exploits that dangerous "little knowledge" it has acquired, this is a part of the price we must all pay for freedom of communication and expression of opinion. I am sure Dr. Tillim would not wish us to abridge this freedom in order to prevent exploitation by an occasional charlatan.

Recently we had a visit from our friend Dr. John B. K. Smith, Alaska's Chief of the Section of Mental Health, who was accompanied by Mr. Lloyd A. Morley, Director of the Division of Medical Facilities of the Health Department. By 1962 or early 1963, they told us, they expect to have completed a 225-bed acute intensive treatment unit at Anchorage; the major emphasis of the program will be an early treatment for psychotics, and this will be combined with a research program. The problems of mental deficiency, long-term patients and acute alcoholics will form a later phase of the program.

The public is showing considerable interest in the mental health program, and many promises of assistance in terms of vocational rehabilitation have been received. Dr. Smith expects that with such local support he will be able to develop a very extensive preventive program. Three traveling clinics, each staffed by a psychiatrist, a psychologist and a social worker, and based respectively at Fairbanks, Anchorage and Juneau, have been in operation for some time. Later the Department will attempt to set up a psychiatric residency program in the new hospital, and also to attract private practice psychiatrists to help develop units in the general hospitals.

I envy this enthusiastic group its unique opportunity to do some pioneering not only in our last frontier state, but also in a virgin professional area. Glasgow-born "Alaska" Smith is a dynamic team leader, and already considers himself more of an Alaskan than a Scot!

I wish I had more space to talk about my recent visit to British Columbia, the purpose of which was to complete arrangements for the survey of B.C.'s mental health needs and resources, which is to be undertaken this summer. I spent much of the time in Vancouver with Dr. Alan Davidson, Director of Mental Health Services, and his staff, and visited the Provincial Mental Hospital and the famous Crease Clinic. Had a delightful day with Dr. James Tyhurst, Professor of Psychiatry at the University of B.C. Medical School and members of his staff. And now there's no room for me to boast about the fact that I was privileged to witness a debate of the B.C. Legisature in the beautiful Parliament Buildings at Victoria—and from the floor of the chamber at that!

Matthew Ross, M.D.

Disciplinary Problems Of The Mentally Retarded*

PETER W. BOWMAN, M.D., *Medical Superintendent*
ISTAR H. YOUNG, Ph.D., *Senior Psychologist*
Pineland Hospital and Training Center, Pownal, Maine

OUR HOSPITALIZED PATIENTS often display many types of emotional difficulties, organic involvements and physical impairments associated with the existing retardation.

Many patients feel, and often are, rejected by their families and by the society from which they come to us. We know that some patients escape from the institution not because they have been abused there but because of a breakdown in their ego structure. We know that a broken window may be only a symptom of emotional disturbance which we may interpret as an indication for therapy rather than as a deliberate premeditated action of what used to be called a "bad boy" who needed punishment.

We must try to have our patients understand that running away and breaking windows do not constitute acceptable behavior. But we must realize that we face individual problems which usually do not respond too favorably to methods of mass regimentation and retaliation often including long-drawn-out investigations for the sole purpose of finding cause for blame and disciplinary action.

Study Begun in Grossly Overcrowded Building

In order to improve our own methods in this phase of institutional management we felt that we should go into the dormitory rather than to have theoretical discussions in a conference room.

We started with a "troubled building" housing boys in their latency period as well as adolescents, most of whom attended classes for the trainables or educables. The degree of overcrowding based on the minimum standards of the American Psychiatric Association was a disconcerting 93.8 per cent. On the first and second floors of the building there were usually 75 patients in a single dayroom. There were only 4 dormitories in all for about 150 boys, and the entire building contained 4 showers, 18 lavatories and 14 toilets instead of 10, 27 and 19, respectively, as are recommended.

We designed a card for each patient and listed, in addition to name, date of birth, and date of admission, such other items as medical diagnosis, physical handicaps, psychological data, mental age, and intelligence quotient. We also recorded on the card other pertinent information such as behavior in the building, emotional adjustment, family contacts and visitors, school record, work experience, leisure time activities, and needs. Finally we listed the respective patient as tentatively belonging in one of five groups.

Group I consisted of boys with a mental age below four years. Group II was comprised of patients who were so inconspicuous and passive that they hardly ever presented a disciplinary problem. In Group III we included all those boys who predominantly displayed healthy signs of childhood behavior and acting out. Group IV was limited to frankly disturbed boys, and Group V was reserved for individuals with sociopathic tendencies (often referred to as "instigators," "ringleaders" or "trouble-makers"), and psychoneurotic disorders.

The data collected were reviewed and interpreted by an experienced psychiatrist assisted by the Cottage Supervisor.

Since most of the younger boys resided on the first floor we separated the two floors in presenting our data. Column A under each Group in the table on page 15 gives information about the younger boys—Column B presents our findings in the older age group.

We soon discovered, as was to be expected, that our disciplinary problems were concentrated in Groups IV and V, the boys with emotional disturbance and sociopathic tendencies, respectively. These boys caused the most trouble, and consequently needed the most attention. They presented a real and sometimes trying challenge in the rehabilitative process.

Information Interpreted for Aides

After the grouping had been accomplished, the problem arose as to how to interpret the characteristics and the needs of the groups to the psychiatric aides who are directly concerned with the day by day supervision and training of the children.

**From a paper presented at the Northeastern Regional Meeting, American Association on Mental Deficiency, October 10, 1958.*

For this purpose, the "house committee" device was used. A committee was made up of the building physician, a psychologist, the cottage supervisor, the attending nurse and the psychiatric aides' supervisor. Meetings were held bimonthly at a time when most or all of the psychiatric aides could attend. The five groupings were explained and their varying disciplinary needs interpreted. Group I, for instance, with a mental age below four years, cannot be expected to understand reasons why their acts are unacceptable. They require immediate and continued correction with careful consistency by all psychiatric aides on all three shifts. On occasion their behavior might have to be reviewed by the physician to determine the need for medical or psychiatric treatment. Also, we should prevent them from being exposed to aggression and exploitation by others.

Other Groups Defined

Group II, it was explained, includes the so-called "good boys" who rarely, if ever, are cause for trouble. However, this group might inadvertently contain a withdrawn or autistic child and so it should be reviewed from time to time in order to identify him and to bring him into treatment.

Group III contains to all intents and purposes the average disciplinary problems. A child with a mental age of six years can be treated as one would deal with a six-year-old of average intelligence. More would be expected of a child with a mental age of ten years and less of a child with a mental age of five years. Little regard was given the chronological age which, however, does create problems from time to time.

Group IV, the emotionally disturbed children, presents a considerable problem and a particular challenge. The best approach in respect to these patients is to bring them into psychiatric therapy as soon as possible. Whatever disciplinary action needs to be taken for the sake of consistency should be determined by the psychiatrist or by a qualified psychologist after consultation with the supervising psychiatrist.

Group V which includes the "instigators" is perhaps the most difficult to deal with in a constructive and successful way. Fortunately, it tends to be small. These boys often seem to be "leaders" and in those cases some real efforts should be made to develop their leadership along acceptable lines. They are usually mildly or moderately retarded or belong even into the borderline classification. Psychiatrically, they include also the various groups of the psychoneuroses and these patients may benefit from psychotherapy and drug therapy.

However, we occasionally find in this group a boy who is capable of learning and who actually does learn to differentiate between right and wrong. Yet he has the capacity to ignore this insight in order to accomplish immediate gratification at almost any cost and in utter disregard of other people's needs or rights. These boys do not seem to show guilt nor do they develop defensive mental mechanisms. They are the few who are probably rightfully classified as "Defective Delinquents" if such terminology is useful at all. Personally, I think the presently available nomenclature provides for it. The word "defective" implies that the individual is delinquent because he is mentally retarded. This, I feel, is not the case, for such individuals do not differ appreciably from the sociopathic personalities so regularly found in our prisons and reformatories. All are correctional problems who, sooner or later, will enter correctional institutions unless a misunderstanding society forces us to keep them in our mental institutions or else requests special maximum security facilities. There is no need for either procedure. They can and should be held responsible for their actions and made to face the consequences in accordance with the law.

Discipline Committee Promotes Communication

It became evident quite early in our study that children got into trouble in other departments "away from home," so to speak, and were sent back to the dormitory building for discipline. This area of action was found to be extremely confused, inconsistent, inadequate and ineffective. It was caused largely by mutual misunderstanding and lack of communication among staff members. It does not take even a mentally retarded patient very long to learn to play one authority against another. In order to arrive at an understanding of the objectives of training and rehabilitation, and work out consistent ways and means of achieving these objectives, a general "Discipline Committee" was established consisting of the head of each department involved or a designated representative. This committee is concerned with developing methods of handling the over-all problem and of learning and teaching others the value of communication. Its efforts are based on the tenet that all those standing *in loco parentis* to the child must form a united and consistent

CLASSIFICATION OF PATIENTS

	GROUP I Mental Age Below 4 Years		GROUP II Inconspicuous & Passive		GROUP III Healthy Behavior Acting Out		GROUP IV Frankly Disturbed		GROUP V Sociopathic Psychoneurotic	
Chronic Brain Disorders	A	B	A	B	A	B	A	B	A	B
With Mongolism	11	3	1	0	2	0	0	0	0	0
Others	0	2	4	8	13	3	2	3	2	1
Mental Deficiency										
Familial—Hereditary	3	8	12	23	10	7	3	9	6	3
Undiagnosed—Deferred	0	1	0	0	2	0	1	0	0	0

team and the treatment of the child must be in accordance with his diagnosis.

This committee has not yet promulgated rules or regulations, if it ever will. Instead it prefers to motivate the staff to consider the need for insightful rather than regulated, and therefore apparent, consistency. To make a rule that any patient who breaks a window shall be put in a room for one week, for example, may actually result in granting a privilege to one patient while decreeing inappropriately severe punishment for another. Still others might not understand the punishment at all because they are not in contact with reality.

With the growing acceptance of the over-all concept of rehabilitation for many of our patients, the emphasis has shifted from maximum conformity through custodial discipline to a dynamic and integrated training for self-sufficiency and socially acceptable behavior in the community.

It is self-evident that such a goal requires that the patient must be taught the limits and be reminded consistently and continuously that such limits exist. He will not survive as an adult in the community until he has learned to live without transgressing into areas of behavior where social retaliation is customary and predictable. The problem therefore resolves itself, at least to a major extent, into a training and learning problem, which raises the questions of how much can our retarded patient learn, and how can we best teach him, and what are our methods in this process.

We have learned that effective training must be based on a thorough knowledge of the individual child and must be geared to his personal needs.

DAY HOSPITAL REORGANIZATION

By D. EWEN CAMERON, M.D., *Psychiatrist-in-Chief*
Allan Memorial Institute, Montreal, Canada

IN THE SPRING of the year our day hospital program was extensively reorganized for the purpose of integrating a range of services which had developed partly independently, but mainly in relation to the old Therapy Unit. The aim is to provide a "cafeteria service" by which a planned combination and frequency of services may be prescribed by the psychiatrist to suit the needs of a particular patient at a particular time. Special emphasis is placed upon group activities directed toward the solution of reality problems which the day-patient faces in his life.

The combination of services ranges in scale from the full-time day hospital stay (8:30 a.m. to 5:00 p.m. every day) to the occasional visit for one particular treatment.

Facilities include a full range of physical treatments on Day Hospital East; the alcohol clinic; and various special follow-up services in addition to the special group activities program on Day Hospital West. The latter is available either full time or in blocks of one-half day to the extent prescribed, and was set up with a view to fostering attitudes other than the dependency necessarily provoked by hospitalization. Its principal aim is the development of a strong group structure for the carrying out of group activities. It provides an opportunity for group interactions to be verbalized, and for the intervention of staff members offering support and encouragement towards rehabilitation, return to work, and return to independent functioning. The program of activities therefore includes:

1) "Work Group"—conducted by a social worker and aimed at discussing problems of employment, psychological blocks to obtaining employment, etc.
2) "Family Group"—conducted by a social worker and oriented toward discussion of family problems.
3) Film show once weekly, followed by discussion.
4) A socio-drama group meeting once weekly.
5) A ward discussion group, which meets daily for one hour before lunch.
6) "Lectures in Living"—This is open to all patients in the hospital, but we have tried to integrate it into the over-all Day Hospital program. Well-known individuals, recognized as local authorities in their own fields, are invited to speak on a wide variety of subjects, such as budget planning, running a house, learning to paint, etc.

We have found that the activity of the day hospital has been greatly extended by this useful reorganization. In fact we have discovered that very disturbed patients can be handled by one method or another within this setting.

Helen Gougeon, food editor of *Weekend Magazine* and author of "Helen Gougeon's Good Food," gives a demonstration in the series called "Lectures in Living."

New Admission Procedure Reduces Trauma

By BERNARD DOLNICK
Superintendent, Ft. Wayne State School, Indiana

FOR MANY YEARS this institution followed the standard admitting procedure for the mentally retarded—sacred routine, rigid regulations and a period of quarantine in the hospital. Newly-admitted patients were dressed in hospital garb and lost their identity in the welter of systems and activities geared to the physically ill. Parents were forbidden to visit during the first twenty-one days, the rationale being that parents and patients both needed this period in which to accept their separation.

In February 1958, however, a new experiment was started. The admissions unit continues to be located in the hospital building, but we have separated it both geographically and psychologically from the area where sick resident patients are treated. It is now contained in a dormitory and dayroom, each measuring about 15′ x 20′, with a bathroom attached. These rooms are brightly painted, well-lighted, cheerfully decorated and appropriately furnished. The dayroom contains a television set, chairs, tables, and plenty of toys, games, comic books and so on.

A group of four or five patients is admitted periodically, all on the the same day, but at different hours. The four or five patients admitted on any given day are of the same sex, chronological age group and mental level. A social worker meets each patient and his family at the administration building and personally escorts them to the new admissions unit. There the patient and his family are introduced to the nurse and to the attendants who staff the unit. The child keeps his own clothing, his favorite toys or other personal possessions. Members of the family are permitted to stay with him for several hours, if they wish. During this time they can tell the unit attendants about his peculiar habits of eating, sleeping, use of the toilet, language problems and so on. Some new admissions, especially the severely retarded, present serious feeding problems at the beginning of their hospital life. In these cases the parents help the child and the staff by staying for a few meals and perhaps even feeding the child if this seems desirable. The parents are given a booklet giving specific information about visiting hours, mail, gifts, etc. and are told that they may come back the next day and as often thereafter as they like during regular visiting hours.

Since a preadmission evaluation has already been done on all newly-admitted patients, there is usually no need at the time of admission for taking further social history or carrying out psychological testing or speech and hearing examinations. Routine laboratory and medical examinations are introduced gently over a few days. After a day or so the Director of Cottage Life, a teacher and other members of the staff gradually and casually visit the new admissions unit to talk with the children, observe them and later make notes.

The social worker assigned to the admission service is a mature, well-trained person who is available to talk with the parents, help them handle their feelings, and answer their questions with authority. She helps with any necessary plans concerning their total family situation.

The attendants on the unit are specially selected and trained. They do not simply supervise the care of these children. They talk with them, play with them and mother them. They are trained to be especially alert and to report their observations on a chart which is kept unobtrusively. These attendants take the newly-admitted children to recreation activities in the recreation hall and elsewhere in the hospital.

After a period of two weeks, newly-admitted patients appear before the diagnostic and staff conference, the members of which they have previously met. This conference confirms the initial cottage placement plans and treatment programs, in addition to establishing clinical diagnoses.

Early Days Close to Community Living

During their first two weeks the newly-admitted patients live in an atmosphere more like that of an ordinary community than of a hospital. They are not introduced to institutional life by being placed in a hospital gown, treated as physically sick people and restricted unnecessarily. Even the severely retarded are offered a gradual transition from home life to living in the so-different community of other mentally retarded people and the employees charged with their care, treatment and training. This gradual transition helps the family also to make a better adjustment. Parents find the letting-go process much easier in an atmosphere which is free and accepting and paced more comfortably by allowing immediate and frequent visits.

This procedure has been in force for little more than a year and it is too early yet to prepare a detailed report on the specific progress made. However, from our experience to date, we feel that the improvements justify continuation of the program. We think that it is successful because it allows true team work in staff operations. Moreover, all members of the admissions unit staff are truly community oriented. They are always conscious of the many inter-relationships of the parents and patient with the outside community, and the special care, treatment and training needs of the patients have been better met as a result of this broader approach. Their concern extends to the families and communities of the patients. Our social worker has been able, for instance, in the last few months, to prevent a mother's nervous breakdown, put a father back on his feet and into gainful employment, and even help an oldest son to find both the financial means and social stimulation to undertake a college education. Some social pathologies, such as delinquency, divorce or alcoholism, have been touched upon and perhaps avoided. We are coming to believe that an important reason for the effectiveness of our over-all program is the fact that we make a careful evaluation of case history material, and help the family wherever possible.

Psychiatric First Aid Service Meets Many Needs

THE AMSTERDAM PLAN

By CONRAD W. BAARS, M.D.,

Director of Education
Rochester State Hospital,
Minnesota

WHILE LISTENING to Dr. A. Querido, the Director of the Central Bureau of Public Health in Amsterdam, outlining the operation of the so-called "Amsterdam Plan," which today is widely used all over the Netherlands, I began to see how this system, suitably modified to meet different conditions in the United States, might well offer a practical solution to the problem posed by our over-crowded public mental hospitals. The plan is based upon Dr. Querido's premise that the rehabilitation of the mentally ill person can only be accomplished in society itself, and that, consequently, a successful stay in society is the only valid test of any therapeutic endeavor. This implies, of course, that the removal of a mentally ill person from his background must be considered an illogical procedure unless indicated for strictly medical reasons.

Treatment More Social Than Medical

For an understanding of this unique mental health service which actually provides social rather than medical treatment in the strict sense of the word, it is helpful to take a closer look at the manner in which the system operates in Amsterdam. This city of approximately 900,000 is rather compactly built, the farthest distance between two points being not more than six miles. There are 22 outpatient treatment centers or "poliklinieken" at which the ambulatory patient can receive specialized therapy provided by his group health insurance program. Each of these 22 centers counts one psychiatrist among its medical specialists. There are two psychotherapeutic treatment centers operating with public grants. The number of psychiatrists in private practice is approximately 75, and the two general hospitals which admit psychiatric patients have together about 300 beds in addition to large outpatient departments.

The mental health service consists usually of 12 psychiatrists, always four or five psychiatrists in training, and about 25 social workers. Two psychiatrists and two social workers are assigned to each of the six sectors into which the city has been divided. They work on a rotating 24-hour schedule. From 6 o'clock in the evening until 8 o'clock in the morning, and on weekends, there is one psychiatrist on duty all the time. There are, on an average, about 3000 adults under supervision, most of whom are living in their own homes and a few in foster homes. The service receives an average of 250 inquiries daily. Some of these can be dealt with by telephone through quick reference to case records. Others require a home visit by the psychiatrist and his social worker assistant for more detailed investigation.

When an official of the police, social welfare, or any other agency or private party calls the center to report a person who he thinks is mentally ill, and when this person is not yet known to the service, the psychiatrist on duty is bound to go out and investigate, as he is not allowed to deal with the case by telephone. In the middle of the night this may be a very heavy duty. It may take two or three hours, talking with the patient and the family; yet it is the only way in which the psychiatrist can get the total picture right at the start. On the other hand, his task may be finished in ten or fifteen minutes by a decision that this is a patient for the hospital because of a medical emergency requiring hospital treatment.

One of the most important features of this psychiatric first-aid on-the-spot service is the opportunity for the psychiatrist to study the conflict in its proper setting. When the psychiatrist and his social worker are called out, they are able to observe and evaluate at first hand the interplay of all factors related to the mental conflict. Without any special effort the total socio-economic picture—quality of surroundings, attitude of spouse, parents, siblings or children, the tensions caused by poor living conditions and poverty, and so on—lies before them. They can see how the patient is feared, loved, respected or rejected; they see the reactions of the neighbors and the attitude of the patient toward authority; they see signs of hobbies, of interest in social or cultural activity; they get an inkling of the burden of material care that rests on the family.

Immediate Psychiatric Decisions Possible

With all this information readily at hand the expert psychiatrist is able to decide immediately whether rehabilitation of the patient in his own surroundings is feasible, or whether for medical reasons hospital stay is necessary. If the former decision is possible, he will find that the attempt to re-establish the disturbed equilibrium is usually of shorter duration, cheaper, more efficient, and more directly concerned with the fundamental con-

flict, therefore offering more chance of success.

It is absolutely necessary for the first on-the-spot contact with the patient to be made by a psychiatrist because the responsibility for the decision and the authority required to back this decision, often under emotionally charged and difficult circumstances, can be assumed only by the expert physician. Although the psychiatric social worker will be valuable in carrying out the necessary case work and further investigations, he cannot replace the psychiatrist. Experience has taught that such a service with too many social workers relative to the number of psychiatrists lowers its effectiveness to the point where it becomes utterly useless. To the often-heard objection that there could not be enough psychiatrists to carry out this kind of work, the only answer is that one psychiatrist in this service has been found to be more effective than all the personnel of a fifty-bed ward!

Patients and Society Learn Reciprocal Acceptance

Another important aspect of this service is its educational impact on the patient who must be educated to accept society, as well as on society and its representatives who must be educated to accept the patient. Every time the service comes into action, it teaches by example how to deal with the mentally ill patient. Usually the first emotion felt by the uninitiated bystander on seeing a mentally disturbed person is one of fear. Often he feels an urge to overpower that person in order to make him harmless. When a psychiatrist, properly trained for this work, enters upon the scene, he demonstrates by his own behavior that a certain situation can be changed by a certain attitude; that, by treating the patient with understanding and honesty, especially honesty, and without showing fear or using force, it may be possible to reduce existing tensions in such a manner that they can be dealt with. The ubiquitous sensation-seekers soon disappear shamefacedly. Instead of seeing a screaming bundle of misery dragged to the ambulance or struggling between two policemen, they watch the patient calmly accompanying the doctor to the hospital or left at home when things have been smoothed over for the moment. It is obvious that such an occurrence cannot fail to leave a deep impression on those who witness it and is apt to change the layman's concept regarding mental illness more than any number of lectures or newspaper articles.

Asked about the problems involved in setting up a similar service elsewhere, Professor Querido emphasized that it should be started on a small scale and be allowed to grow gradually. Although such a service will usually be most needed in the larger cities, it could be established equally well in rural communities. Because of the fact that the service must be ready to meet every personal emergency at any time, there must be no delay or bureaucratic machinery between the moment a problem comes to the attention of the service and the time when the first contact is made by the psychiatrist. Much will depend here on the relations between public authorities and various agencies already in existence. The personnel in this service must show a warm understanding of human needs and a matter-of-fact equanimity toward any of the multitude of incredible situations which may occur at any time.

The Amsterdam Plan

"In the first place, the service can be described as a buffer mechanism between the patient and society in which you can adjust the social pressure to the needs of the patient. That is more or less the principle. You have patients you must free from all social pressure, and you have to send them to the hospital; and you have patients who can stand just so much, and you have to adjust the social conditions of these patients so they get only that much pressure and no more. Therefore, you may give the patient certain material aids. You may give him money. You may give him clothes. You may give him a job. That never has the same meaning as the giving by, let me say, the Bureau of Public Assistance. It is not a dole. Nor is it a bribe. It is, indeed, a medicine. You have to handle it as such. You have to insist very much that it is the psychiatrist who determines the material aid, always with the needs and the medical facts of the patient in the background.

"The situation you have with the patient is not a therapeutic situation in the orthodox sense, but is an authoritative one. You more or less represent the good, the giving, the permissive aspect of society toward the patient. Therefore, it follows that you can deal with such patients for whom this situation is acceptable and of therapeutic value."

Dr. A. Querido, "Early Diagnosis and Treatment Services." Elements of a Community Mental Health Program, Proceedings of a Round Table at 1955 Annual Conference. Milbank Memorial Fund, 40 Wall Street, New York 5, New York.

It is immaterial whether such a service is set up by state, county, city or by private bodies or organizations. It may be run by one hospital alone, or by a group of hospitals; or private organizations and voluntary societies may unite to set up such a service. In the beginning it would be advisable for the service to limit itself to one or two groups of patients such as alcoholics, drug addicts, disturbed geriatrics, or suicidal patients. The speed with which the service should be allowed to develop will depend on its initial success with these patients, the cooperation the service will obtain from other organizations, the time it takes to overcome the opposition from the families of patients, other hospitals, psychiatrists in private practice, etc.

It is, of course, impossible to estimate the total number of hospital beds that have been saved by this service, or the number of hospitals that did not have to be built, or any of the other savings that have been made possible. However, the over-all success of this domiciliary system in Amsterdam as well as in other Dutch cities and communities during the 30 years of its existence has been such that its principle warrants close study and investigation for eventual applicability in various American communities.

A Possible Solution to Staff Shortages

Career Residency Programs in Psychiatry

By R. M. VAN MATRE, M.D.
Chief, Psychiatric Training, VA Central Office
and DOROTHY M. RICHARDSON
A.P.A. Statistician

WHAT IS THE CAREER PROGRAM for residents in psychiatry and how does it operate? In response to an increasing demand for information on this subject the American Psychiatric Association sent a questionnaire to the Veterans Administration and to each state and province in the United States and Canada having approved residency training programs in the mental hospital systems.

The questionnaire was designed to ascertain the number of "career" programs and the number of participants past and present, the methods of administration and the official attitudes toward the plan. For the purpose of the survey the career or obligated program was defined as "a psychiatric residency program wherein the trainee accepts an obligation for service in exchange for a position on the medical staff at a higher salary level than is usual for residents." With only one exception answers were received from all states and provinces contacted.

At the present time there are 419 physicians participating in career programs in thirteen states, five provinces and the Veterans Administration. All of the programs in the United States have been started since 1952 and five are as recent as 1956-57 and 58. Those who have only recently become aware of the career plan may be surprised to learn that Canada has had such programs for over eleven years, one having been started as far back as 1935. The plans differ from state to state and in the provinces, but all have one thing in common: the physician obligates himself to serve a specified period in a mental hospital in exchange for special training or training at a higher salary level than is usual for residents.

Most Programs Too Young for Predictions

With the exception of those in provinces and four states, most of the programs have been in effect for too short a time to predict how many of the participants may be expected to remain in the system at the completion of their training and obligated service. The Veterans Administration, with its many psychiatric hospitals and psychiatric units in general hospitals, has understandably the largest program with 176 physicians now in training and 63 in obligated service. Of the 65 who have finished both training and service since the inception of the VA's program in 1952, 34 are still in the system. In the four states which have had programs in operation for over five years, 11 of the 22 who have completed training and service still remain in the system. The same ratio applies to Canada where approximately 104 physicians out of 219 finishing the course have remained in the service. The number of physicians in training in each program seems to be related more to the teaching strength of the central facility than to the age of the program.

In many of the states, obligated service may be performed either during the training period or at the end of this period. Six states require the service before training is completed. The majority of the states require two years of service for three years of training, while in Canada the obligated period of service is one year for each year of training. One province requires two years' service for each year of university training. Canada also differs from the United States in that in four provinces only four years of training and experience instead of five are required before a physician is eligible for certification.

Financial Arrangements Vary

Financial arrangements and salary rates vary considerably. In Canada the salaries range from $3,000 to $8,340 a year, and in the United States from $3,600 to $12,960. The ranges by themselves, however, are somewhat misleading as various other factors enter into the picture. In Canada, for instance, there are supplementary benefits such as bursaries from the Government, fellowship or teaching appointments, travel and book allowances. In the United States, salaries are usually increased from year to year, but other benefits are seldom given.

One important and universal question is how to insure that a participant will perform his obligated service. All programs expect to be reimbursed in money if the resident fails to perform some or all of the obligated service. In ten programs the participant is required to sign a legal contract; two rely on the moral obligation of the resident either to perform his service or to repay the state or province; seven programs ask the participant to sign a written statement of understanding. Most programs, but not all, have some provision for prorating repayment if some portion of the obligated service has been rendered.

There are some states which do not have career residency programs and apparently do not wish to have them, even in the light of the satisfactory results achieved in other places. Six of the states contacted

said they did not want obligated service programs. Some of their comments were: "It may be a good idea, but it doesn't seem quite suited to our organization." "Basically, we feel the implied mutual obligation of such a program would be inconsistent with our obligation to the patients and the public." On the other hand, four states are seriously considering adopting the career plan if legislative approval can be obtained and administrative obstacles overcome. Also, some of the states without programs indicated extreme interest in how such programs were operating in the other states and provinces.

The A.P.A. questionnaire concluded with a request for comments on the career program, its successes, failures and problems. One respondent cited as the greatest problem, "the number of participants who 'buy out.' In most of the programs three years elapse between the signing of the contract and the beginning of the obligated service. During this period the resident's perspective, aims and ambitions change as a result of the broadening effects of psychiatric training and experience. For this reason some losses are inevitable." (One large program has increased the amount of required reimbursement in an effort to reduce such losses.)

One state reported, "Our obligated time is too long. We are trying to get this changed."

Another stated, "Program new—has not been pushed because of the press of other administrative problems. Believe would be successful if forcefully pushed."

Still another said, "We have had so few residents in this program that it is difficult to comment on its success or failure."

These extracts are quoted to show that the objections which do exist are directed to administrative problems rather than to the principles involved.

On the positive side the following comments are of interest.

"We are most enthusiastic about this program. We have found the graduate of the five-year program has matured to a greater degree and is better rounded in terms of training and experience than the three-year man. The difference is quite marked."

"Working out satisfactorily as far as this province is concerned."

"Has been a big help in obtaining young, therapeutically-oriented psychiatrists. Recruitment was formerly a major problem, but seems to have lessened."

"To date we think the program is successful but it is too early to know definitely. More men are becoming interested in the program each year and it has been easier to fill the career vacancies."

Eight respondents made no comment or referred principally to the newness of the program in their states. No state or province indicated any desire to abandon its obligated service program.

ED. NOTE: *An analysis of the individual Career Residency Programs is being sent as a supplementary mailing to North American subscribers to the Mental Hospital Service. Extra copies are available upon request.*

beside tubs and beside toilets are a great aid to feeble

Restraint and seclusion should be used only when

How the C.I.B. Rates Facilities for Patient Care

By CHARLES K. BUSH, M.D.
Chief Inspector, A.P.A. Central Inspection Board

ONE OF THE nine hospital departments considered as "essential" in rating by the Central Inspection Board groups the basic necessities for the comfort of the patient under the general heading, "Facilities for Patient Care." Included are cleanliness, sanitation, furniture, furnishings and decorations, toilet and bathing facilities, clothing, laundry service, barber and beauty parlor services, canteen or shopping service and the controlled use of restraint and seclusion.

Cleanliness and sanitation go hand-in-hand and are most important in any hospital. It would be best to have one individual responsible for housekeeping in all areas; however, this is frequently divided among many people who have different ideas of cleanliness. A housekeeping service, responsible for cleaning all areas, is highly desirable. If this is impossible and there are sufficient persons in the nursing service so that some can be assigned this duty as a primary function, this alternative might work satisfactorily, but when there is a shortage of nursing personnel, either the housekeeping suffers or the patients do not receive adequate personal care.

Although sanitation should be the responsibility of all employees, some one person should be responsible for the over-all supervision of this program, should make inspections at regular intervals and report to the hospital director on all unsanitary conditions observed. All personnel should report promptly to this individual any evidences of rodents or infestation with insects. Attics, basements and storage areas should not be forgotten in assigning housekeeping responsibilities.

Furniture Should Be Comfortable and Attractive

Bedroom, dayroom and dining room furniture should be comfortable, attractive and adequate. Beds should vary according to the types of patients who will be using them. For bedfast patients, regular hospital beds of the Gatch type are preferable. For patients who use the beds only for sleeping, a low bed, at least 36 inches wide, is desirable. Beds should be kept in good repair; sagging springs should be replaced and the beds should be repainted whenever the paint becomes chipped. Lumpy cotton pads are not comfortable and mattresses should be of much better construction. Many hospitals have used foam rubber and like it very much. Others use plastic coated hair or heavy cotton mattresses. Bedside stands or lockers should be provided.

Dayroom furniture should be sturdy but comfortable. Hard, straight wooden benches are neither comfortable nor attractive and do little for the patients' morale. Many hospitals are using chairs and tables with tubular steel legs, the chairs upholstered in a heavy plastic. Dayrooms should contain various sized tables for different purposes, bookcases and a piano. Many hospitals have been able to place used pianos in all dayrooms simply by informing nearby communities that they will send after donated pianos if they are in usable condition.

Dining room furniture should consist of tables with easy-to-clean tops and room for four to six persons; comfortable chairs should be provided. Cafeteria style service is preferable for all patients who are able to handle a tray. For bedfast patients, an over-the-bed table is desirable.

Decoration and Appointments Help Brighten Wards

The use of window shades, venetian blinds, drapes, pictures and flowers or potted plants does much to make all parts of the ward more attractive and pleasant. A variety of tints, shades and colors in the decorative scheme also helps minimize an institutional appearance. Maintenance departments are sometimes obstinate about using anything but "institution buff" but when they see the changed appearance of one building decorated with a variety of colors, they are usually won over. Drapes and bedspreads in a variety of colors also help to brighten a ward. Some hospitals have had murals painted on the dayroom walls as an occupational therapy project.

Toilet rooms and bathrooms should be separate and should provide the number of fixtures which are recommended by the A.P.A. Committee on Standards and Policies of Hospitals. According to these ratios there should be one washbasin for each six beds, one toilet for each eight beds (a urinal or sani-stand may be substituted for one toilet for each twenty-four beds), a tub or shower for each fifteen beds and at least one drinking fountain, preferably refrigerated, on each ward. There should be one washbasin in each toilet room. Some hospitals have found dental basins are very useful and have installed one or two in each washroom. Showers and toilets should be in individual stalls so that the patient can have some degree of privacy. On wards which have infirm or bedfast patients, high pedestal tubs save much work for the employees. Rubber mats on the floors of shower rooms prevent many accidents, and grab bars in shower stalls,

beside tubs and beside toilets are a great aid to feeble patients. There should be an adequate supply of towels, wash cloths and soap at all times. Toilet paper should be available beside each toilet except where there are very regressed or disturbed patients. Sanitary napkins should be available for female patients who need them.

An adequate supply of clothing should be provided for all patients and the appearance of a uniform should be avoided. When relatives are financially able, they should furnish clothing and they should be informed as to the needs of their patient from time to time. Whether home-furnished or hospital-furnished, clothing should be fitted to the patient and should be marked with the patient's name. The only legitimate reason for marking clothing with the ward number is to identify that which is to be used for untidy or destructive patients. All patients should have an adequate supply of underwear and night clothes and either handkerchiefs or tissues should be provided.

Laundry and dry cleaning services should be available so that clothing can be washed or cleaned and pressed. Clothing that has been properly fitted and then is returned from the laundry "rough dry" is damaging to a patient's morale. Many hospitals set up a small laundry room on some wards where patients may wash and iron some of their own clothing, thus relieving the load on the laundry, as well as supplying patients with a "normal" activity.

Barber and beauty shop services should be available to all patients. Those who are physically and psychiatrically able should go to a central shop for these services. Patients who can shave themselves should do so daily with a locked safety razor or an electric razor. Barber shops should be modern, and electric clippers and lathering machines should be provided. Beauty shops should provide permanent waves, hair sets and shampoos and should train patients to care for their hair, skin and nails. Beauty and barber services should also be available on the wards for patients unable to go to the central shops. Both barbers and beauticians should be experienced and have the patients' interest at heart.

Patients need to be able to buy treats and small articles, and this need should be met by providing a canteen or a shopping service. If the hospital operates a canteen, the prices should be low, and all profits should be used to provide more comforts or entertainment for the patients. Suggested items to be sold in canteens include soft drinks, ice cream, tobacco products, sandwiches, pastry, magazines, newspapers, notions and perhaps small items of clothing.

Restraint and seclusion should be used only when other methods fail and should always be on the written order of a physician. P.R.N. orders for restraint are not encouraged and a 24-hour limit on any order is recommended. A regular prescription form should be provided and the time of beginning and ending of the restraint or seclusion should be entered on the reverse of the slip. These should be sent to the records office daily. The medical records office should compile figures on a monthly basis and submit the report to the hospital director for comparison with previous months. Patients in restraint or seclusion should be given close supervision and should be released for a few minutes at regular intervals to take care of toilet needs, to eat, and to enable staff to determine if they have quieted down sufficiently so that restraint or seclusion is no longer needed.

Sedative drugs in larger than ordinary medicinal doses are used in some hospitals instead of mechanical restraint. This should be considered as chemical restraint and accurate records should be kept just as for mechanical restraint.

In general, the rating of the section on Facilities for Patient Care is an attempt to judge the over-all care of the patient in other than psychiatric or medical areas. Patients should be treated as individuals and the dignity of the individual should be maintained. Regimentation and inhumanity have no place when dealing with mental patients, and the Golden Rule should be the Standard Operating Procedure.

THE AMERICAN PSYCHIATRIC ASSOCIATION ANNOUNCES

THE ARCHITECTURAL SERVICE

A new consultation service for the planning, designing and equipping of psychiatric facilities

Including:

Public Mental Hospitals, Private Psychiatric Hospitals, Psychiatric Units in General Hospitals, Mental Health Clinics, Day Hospitals, Night Hospitals, Half-Way Houses, Sheltered Workshops, Residential Units for Children, and Special Facilities for the Aging.

This service is available to:

Architectural and Engineering Firms, Heating and Lighting Manufacturers, Equipment and Furniture Manufacturers, Community Organizations, Government Agencies, Hospital Planning Commissions and Related Groups.

Resources:

Since 1953, the American Psychiatric Association, in cooperation with members of the American Institute of Architects, has been conducting studies of the environmental requirements for psychiatric care. The dominant objective has been to teach psychiatrists to write a medical program readily understandable by the architect; and to enable the architect to translate this program into modern, functional designs which will give patients the freedom compatible with their illness. To do this required the development of methods whereby the language of psychiatry could be translated into architectural terms; it also required architects and psychiatrists to conceive of a facility as functional, aesthetic and modern as the use of present-day technology will permit.

The original study project was financed by grants from the Rockefeller Foundation, The Division Fund and the National Institute of Mental Health. During the ensuing five and a half years of research, a considerable body of data has been collected, and operating principles defined. The time has come to put these data to practical use.

To this end, the A.P.A. Architectural Service has been established as a means of making available the material collected by the study group. Through this service, the study data can be specifically applied to each individual project.

Design for Therapy

The guiding principle of the Architectural Service is to work with those responsible for the construction of mental health facilities of all types, to provide buildings in which a modern program can flourish. Such facilities include the well-known public and private psychiatric hospitals, psychiatric units in general hospitals, clinics, day hospitals and residential units for children. Newer facilities, such as night hospitals, half-way houses, sheltered workshops, mental health centers and special facilities for emotionally disturbed children and the aged also come within the purview of the staff of the Architectural Service.

The Architectural Service will be of the greatest value during the earliest stages of planning. Those who are charged with letting the contracts will find it valuable: hospital administrators and administrative psychiatrists, business administrators at state and hospital levels, state public works departments, hospital planning commissions and community groups planning the development of psychiatric treatment centers. Those whose job it is to translate the medical program into construction—architects, engineers, decorators, heating and lighting experts, equipment and furniture manufacturers and the like—will find that the Architectural Service staff can offer them a vast fund of information.

Ideally the service will include an on-the-site visit and a meeting between the planning group and the Architectural Service staff, and detailed consultations with the architects and others charged with the construction of the facility.

Design Clinics

In addition to the standard consultation service, seminars will be held from time to time, modeled after the experimental "Design Clinics" started during 1958. These will be two- to three-day seminars for limited numbers of architects and related professional people and the administrative group charged with hospital planning. Their primary purpose will be a general appraisal of the design requirements for specific psychiatric facilities.

On the request of state or local authorities regional design clinics will be set up to review and appraise construction programs for the region. Institutional representatives will present their plans to be viewed in the light of over-all needs and resources; recommendations will be made accordingly. Various experts will assist in the review of the plans and help to bring to the state or region an objective, professional outside point of view.

Cost

The grant-supported study phase of the original project has terminated, and the new Architectural Service will be self-supporting. Consultation, therefore, will be furnished on the conventional fee-for-service basis plus travel expenses.

For Further Information

Write to Mathew Ross, M.D., Medical Director, American Psychiatric Association, 1700 Eighteenth St., N.W., Washington 9, D.C.

Youth PERVADES HALF-WAY HOUSE AT NIMH

By JOSEPH D. NOSHPITZ, M.D.

Child Research Branch, Clinical Investigations
National Institute of Mental Health
Bethesda, Maryland

THE RESIDENCE we are about to enter is a young one, only eighteen months old, and it houses six puberty age boys who are part of a research program at the National Institute of Mental Health. These six boys were originally admitted to a closed ward at the Clinical Center of the National Institutes of Health because they displayed aggressivity and recalcitrance in their social behavior, and thus became appropriate subjects for a study of treatment methods for the hyperaggressive child.

In the course of their treatment, a combination of psychotherapy and intensive milieu, they went through various regressive and severe acting-out phases. Gradually, however, they showed improvement enough to warrant movement to a "half-way house," a development which had been anticipated by the construction of a "cottage" on the grounds of the National Institutes of Health.

This cottage is located perhaps a quarter of a mile from the main hospital building and is thus somewhat apart, although by no means totally isolated, from the original treatment area. Expressed in the construction is a certain philosophy which might roughly be stated

At special times the arts-and-crafts rooms are opened so that children may work quietly at special projects.

as follows: these children, although emerging from the closed ward institutional type of life, are still in an institution and not in a home. It was therefore necessary and proper to include in the structure those elements which would be more institutional than homelike, such as staff offices, an apartment for the cottage mother, living quarters for counselors, and so forth. At the same time, the function of the building is to act as a transition and to begin to re-teach many of the details of normal home living to this group of very disturbed children, and therefore the setting should be relatively middle-class typical in respect to floor plan, furniture, dishes, curtains, and the other accoutrements of interior living.

The new building is modern in design, flat-roofed, and shaped somewhat like a lopsided letter "T". There are two floors and a basement, and the sloping land on which the building is located allows for entrances on several levels. The upright of the "T" exists only on the floor above ground level and is in fact a sort of elevated corridor. The crossbar of the "T" is divided into two uneven segments: the children's part, much the longer of the two, is on the left as one enters; the counselors' section on the right.

Guided Tour Includes Treatment Philosophy

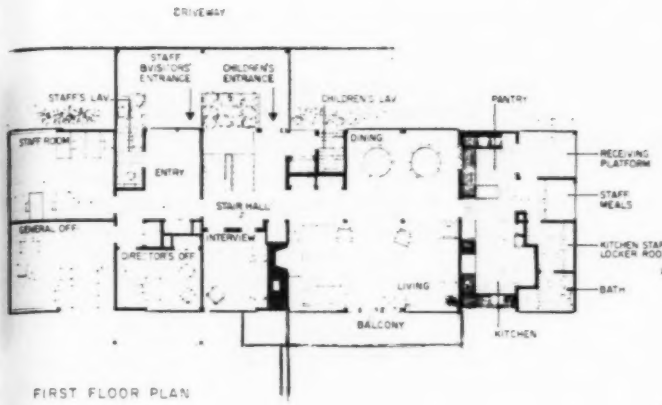
It might perhaps be useful to study the building by entering through one of the main doors and making observations as we travel along. We will explore the ground floor first, passing through the dining-living room and kitchen, and then through the staff offices. Following this, we will go upstairs, tour the staff and patient quarters, and finally, descending to the basement, give some attention to the shop and rumpus areas. In the course of these wanderings some observations will be made on treatment issues that arise in connection with the way management and space distributions interact.

The main entrance on the ground-floor level consists of two doorways set adjacent to one another. The doorway on the left is kept open all the time and is the

Ed. Note: All pictures in this article are posed. None of the children shown are actual patients.

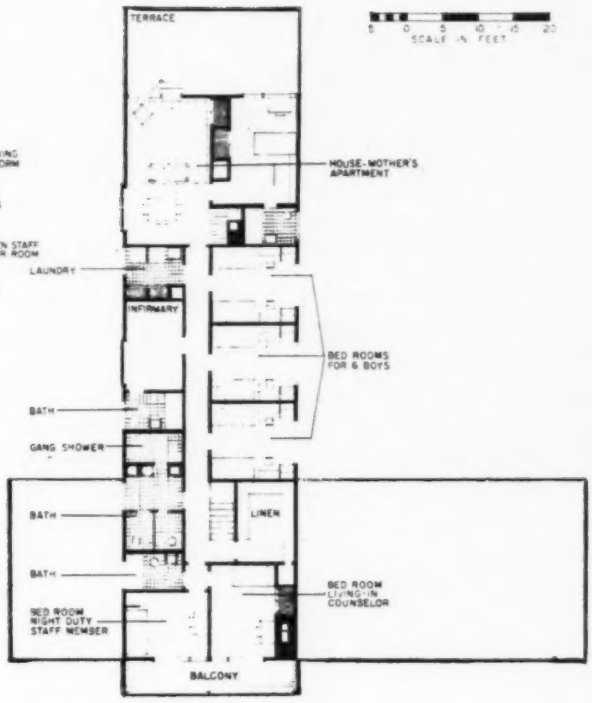
Interpersonal relations are furthered when the boys help each other with creative pursuits or hobbies.

The covered play area at ground level is a link [illegible] outsi[illegible] can indulge in rough-and-tumble activities, and the [illegible]y quiete[illegible] from the rumpus room in the basement to the sl[illegible]ters or[illegible]



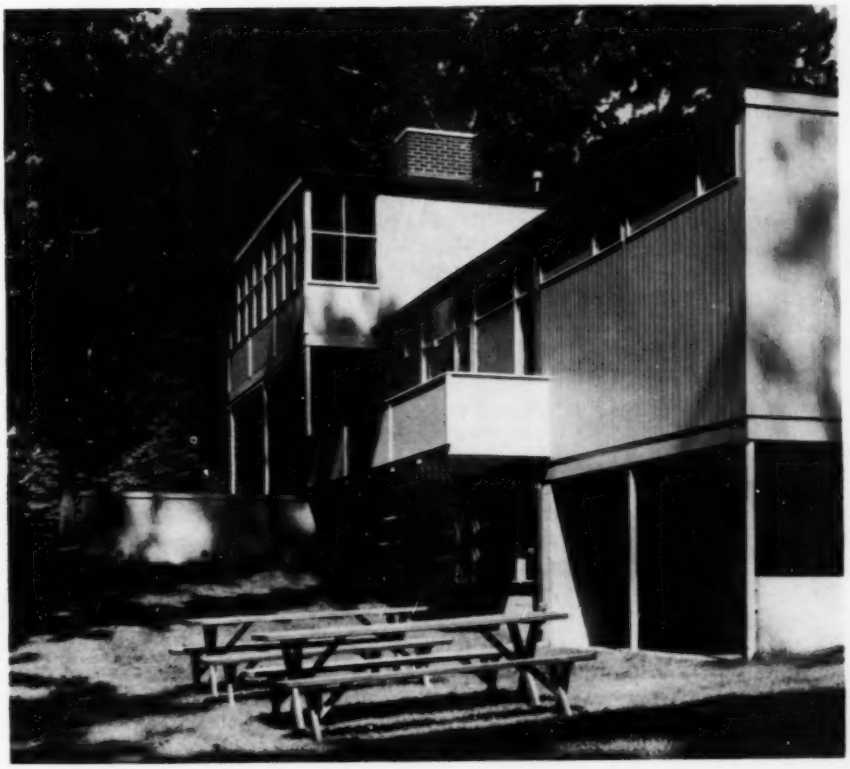
FIRST FLOOR PLAN

BASEMENT PLAN



SECOND FLOOR PLAN

a link [illegible] outside, where boys and the [illegible] quieter areas indoors o the [illegible]ters on the top floor.



entrance to the children's quarters. The other doorway, which permits access to the counselor-staff portion of the building, is kept locked. Through the door on the left, one enters in the shadow of the elevated corridor and finds oneself immediately in the anteroom of the children's quarters. On the left is a small bathroom with toilet and sink for the use of the youngsters when they are playing outside or occupying the day-hall, which is a combination living and dining area on this floor.

A word should be said here about the choice of these two areas in a coextensive relationship. It is particularly useful from the treatment point of view that the ebb and flow of movement from living room to dining room be fairly free, since the behavior appropriate to these two areas is similar, i.e., it must be rather well-controlled behavior, inside-of-house-oriented in character, and emerging from the good manners and good practices that are part of every child's training during the latency years. Moreover, the living-dining area is best kept distinctly apart from rough play areas where tumbling, wrestling and the like take place. The structural compartmentalization thus comes into the service of creating appropriate psychologic separations.

As one passes through the day-hall, the dining area is on the left. This is of moderate size, a sort of alcove or nook containing two tables, each of which accommodates three boys and one or more counselors during mealtimes and snacks. The far wall of this living-dining room serves to divide it from the kitchen, and allows communication with the kitchen through two openings—a counter shelf across which food is served, and a door to permit entry into the kitchen proper.

Children Have Free Access to Snack Refrigerator

The philosophy of treatment is such that an attempt is made always to keep food available to the children. During the day, they are kept out of the kitchen but after 7:00 p.m. when the kitchen personnel have left, the youngsters have free access to this area and, in particular, to the refrigerator where food is available to them. An additional and much larger food freezer, also located in this kitchen, is kept locked; here the staples are maintained for the cottage. There is a separate dietetic staff whose sole responsibility it is to prepare the food and serve it to the children. This staff has its own entrance as well as its own shower and locker room and can come and go independently of the life of the children and the flow of treatment in the cottage.

As we turn from the kitchen and make our way back through the dayroom, we come once again to the entrance hall where two doors at right angles to each other confront us. The one to the left leads to the interview room, a room fully accessible to the youngsters and containing a table and several chairs. It provides an opportunity for interviewing an individual child very close to the site of his daytime action; a place for individual tutoring or for doing homework away from the group; and a partial or temporary isolation spot for a youngster who needs to get somewhat—but not entirely—away from the center of things. Such a room is of enormous benefit to the ongoing program. There have been many times when the counselor staff has expressed the wish for more than one such room so that at least two youngsters might be seen simultaneously by different staff members.

Invasion of Staff Areas Big Problem

The other door in the entrance hall opens into the staff portion of the ground floor. Since many events of considerable treatment interest take place in and about this staff area, it is worth remarking on in some detail. Briefly, there is an anteroom into which one enters by either of two doors, the one from the outside (via the right main entrance door described above) or the one that opens from the patients' half of the house.

One of the major complications of children's treatment residences is the permeability of staff areas by the children. This is so ubiquitous a problem that it may properly be considered a unique feature of residential treatment life. Some of the young invaders are so aggressive that it takes all the talent and skill and sometimes all the strength of the staff to effect their departure back into the patient area. Sometimes these invasions are occasioned by simple curiosity, sometimes by more complex sexually oriented curiosity, and sometimes merely by difficulty in effecting separation at moments of stress. Theft will not infrequently occur in the course of such invasions and occasionally outright vandalism may be featured. It is therefore of the essence to have the staff area so arranged that if children do break in they are not immediately in the innermost sanctum but find themselves at first in a preliminary chamber where they can be intercepted and where some attempt can be made to work with them before they get any further. One additional and very valuable function has developed for this anteroom. A cabinet containing highly prized personal items belonging to the youngsters has been located there so that someone's school project, or special hair tonic, or whatever, can be held available for him safe from the depredations of the others—stepping in to get these things serves the useful function of allowing entrance into the staff quarters under controlled and appropriate circumstances.

A staff toilet and a closet for hanging staff garments open off the anteroom through which one also has access to three other rooms. The first of these is the director's office used chiefly as a private office, not infrequently for conferences, and occasionally as a place where children can be interviewed for particularly serious problems. The second room is the secretarial office where the two secretaries keep their files, desks and equipment, and where two of the senior staff members have their headquarters; the third room is the staff room proper which serves a host of functions; conferences are held here, individual desks are assigned to various staff members, and the daily records are kept here for the oncoming shifts to read. Here too, individual supervisory meetings are held between senior and junior staff; full-scale group meetings from total staff assemblies to single-shift team meetings take place. The message center is located in this room with the bulletin board usually filled with all sorts of notes; the blackboard on one wall is used for much of the daily information exchange as well as for teaching. Many of the jokes and pranks so necessary

for the morale of young imaginative child-care workers find expression here. Finally, this room can provide a place of refuge from the wear and tear of cottage life for the staff person who has perhaps been through an exhausting series of interviews during two hours of trouble time and who just wants to get away from it all for a few minutes.

Returning to the children's half of the ground floor once more, we note that there is a staircase on our right just inside the main entrance. This staircase leads to the upper floor of the building and in itself marks a site of considerable ebb and flow of personnel and patients and of occasional struggle between them. Staircases seem made to order for children's rough play—one can push and nudge others as they are going up or down stairs, one can fight a rather effective delaying action against superior odds if one has to be taken to one's room and desires not to be, and one can leave sleep behind in the morning by abandoning the place of sleep in the definitive manner that "coming downstairs" betokens.

Sleeping Rooms Upstairs but Easily Available

As we ascend the stairs, we come into the elevated upright of our "T" which serves as the sleeping and staff dwelling part of the cottage. It can well be argued that, in order to allow for supervision and prevent withdrawal, the sleeping rooms of patients should be closed off from their daytime living area except at bedtime. On the other hand, the opportunity for a youngster to withdraw from the melee of life into his own chamber for brief moments of repair, rest, and simple insulation from the stimuli of the environment proves at times to be invaluable in a therapeutic setting. It becomes important, therefore, to have sleeping rooms easily available from, and yet not too near the site of other activities. If our cottage were a one-story building, we would have arranged to have the sleeping rooms located somewhat apart from the dining room, living room and play areas. With the bedrooms situated on the second floor, we automatically get this measure of distance.

Another essential for adequate sleeping room arrangement is some degree of separateness of one room from another and a high level of sound insulation around each room. For youngsters living in a residence are supremely liable to the phenomenon of group contagion —a little bubble of excitement that might begin to bounce up and down in any one chamber can move as a froth very readily into the next, the next, and the next, so that in a flash, instead of having one or two disturbed youngsters to cope with, one finds oneself inundated by an entire cottage full. The separateness and the noise insulation if available would provide at least a partial block to such transmission. From our point of view, our structure is defective in this respect because the sleeping rooms of the children are lined up one next to the other with relatively thin walls between them.

A second feature that should be part and parcel of the sleeping arrangement of any unit for disturbed children is the availability of beds which are not included as part of the official hospital bed-count and not ordinarily filled, but which can be filled either temporarily or in a semi-permanent manner, depending upon disturbances or breaks in the social grouping. Almost invariably in any arrangement where there is more than one child in a room, there come moments when the youngsters will disagree with one another or where one of them, because of some external problem, will begin to take out his difficulties on his roommate in the form of sexual seductiveness, aggressive attack, interference with sleeping, or other stimulating behavior. There should be provision for such a child to be separated from his companions at bedtime and managed alone. This has to be done without total disruption of the pattern of room placement lest there ensue an incessant game of musical bedrooms which keeps everyone at sixes and sevens. This extra bedroom was not provided officially in our establishment but was obtained in a somewhat indirect way by utilizing an infirmary room across the hall from the three two-bed rooms. The infirmary bed has come in very handy on a number of occasions. For instance, we used it for one of the youngsters who became disturbed during some family problems and had to be literally physically restrained around bedtime to prevent his wreaking severe damage on his roommate. The infirmary is also intended, of course, for the function that gives it its name, i.e., as a place for the child who is physically ill in some way and who needs some extra care and attention and/or isolation. The room contains merely a bed, a chair, a scale, and a cabinet where the medicines and the examining tools can be kept locked. In addition, it has its own private bathroom.

At the head of the staircase, we find a door on our left which is ordinarily kept locked. This door opens into the linen room which also houses the children's laundered clothes and has in time developed a second function, i.e., it is the place where laundry is counted and sorted. This is an activity where children can often help adults and it offers a good "task" to incorporate into programming.

Staff Quarters at Each End of Corridor

The children's sleeping rooms branch off from a passageway flanked on each end by staff quarters. The sleep-in counselor's quarters on the one end of the corridor provide two rooms and a bath; the cottage mother's apartment on the other end includes a bedroom, living room, and kitchenette. This latter area is one of tremendous treatment meaning to the children. The cottage mother can invite them in or, if they do it properly, they can invite themselves in periodically for a real training experience in social living. This is not their residence; it is not any part of their living quarters; they are here as visitors on the condition that they behave appropriately. Where they put their feet, what kind of language they use, how they comport themselves with another person's property—all these assume a very different character than they have in the day-to-day living with their peers or even with the counselors. Here the youngsters can be taught many of the smaller but vital formalities of good manners in the special setting of visiting with the cottage mother in her home, and here too vital relationship issues can come to light and be worked with in a natural way. The emotional first aid and tremendous amount of therapeutic work that

pours into the youngsters through contacts with the housemother will be dealt with in a number of papers on this subject coming from this setting; from our present point of view, it suffices to stress that the cottage mother's apartment and children's quarters need be very close to one another.

As we explore the corridor between the staff quarters, we find a number of additional rooms opposite the children's sleeping rooms. A washroom containing washing machine and dryer has been located between the cottage mother's apartment and the infirmary. In view of the relatively expensive and potentially dangerous equipment it contains, this room is ordinarily kept locked. There is in addition a group bathroom containing a gang shower and two toilets. During the acute phase of treatment, it is probably best for youngsters of this sort to have individual showers and toilets because the stimulation of these pre-genital cleaning, bowel, and urinary functions is such as to evoke a good deal of sex play and excitement on all levels. It is a matter of some maturation and progress before these youngsters can utilize a group bathroom as something other than a source and site for acting out. In a half-way house type of setting, however, one can attempt this with the proviso that a separate bathroom be located in the infirmary. This allows for at least temporary care of the transiently disturbed child until such time as he reconstitutes and can rejoin the group.

In our setting, the patient bedrooms are designed for two patients each. The cabinet space in these rather small rooms is built in and provides space for hanging clothes and for keeping books, supplies and equipment. There is also a locked area to which the counselors keep a key. This latter is to give each youngster the solid assurance of having a place which no one can get into without the help of a counselor. Here his favorite things can be locked away and the key cannot be stolen or extorted from him. There are two identical mirrors, one over each bed. In addition, a table is located in the room with two chairs set before it—thus each half of the room is a mirror image of the other half (and questions of sibling rivalry and the like will have to take some form other than envying the structural elements that might benefit the one or the other of the two occupants).

Basement Contains Rough-Play Rumpus Room

The above is perhaps a sufficient description of the upstairs and we might turn our attention with profit to the basement. This is an extended area running along full length under the cross bar of the "T". It has its own entrance—also at ground level because of the slope on which the building rests. This out-of-ground quality is true only on one end; the other end of the basement is fairly deeply set in the earth with only the upper two or three feet of each room above ground. However the rumpus room play area part of the basement is actually on ground level and there is easy access to it from the grounds around the cottage.

The basement provides several highly essential elements of cottage life, not the least of which are the heating and air-conditioning plants. Probably the most important part of the basement, from the staff point of view, is the blessed additional storage space where large and bulky items can be kept—these are elements which always create havoc in the setting unless space is built in for them. Psychologically, having adequate place to dump things and get them out from underfoot is one of the most useful and valuable props that the functioning of such a life program as ours can have.

A compact and rather well-designed woodshop and an arts-and-crafts room are at one end of the basement. Ordinarily these areas are kept closed—at special times they can be opened and the youngsters can work there either with or without counselors, depending upon the nature of the problem undertaken and the state of the child at the time. The details of the shop equipment are not sufficiently different from the norm to require special description.

Toward the other end of the basement is a rather large, very pleasant, rumpus room designed for the rougher kind of play. It is invaluable as a part of the life of young teenagers, since it permits behavior that is wild and woolly but still in-the-house in type. This room subserves another function as well—it is the official TV viewing area. The rumpus room in turn opens into a type of covered carport which is designed as an outdoor play area. Here the youngsters can be active, keep a pet, and engage in projects of various sorts that would not do well inside the house but need some shelter from rain and inclement weather.

Areas Provided For All Gradations of Activity

In general, the arrangement of living room, rumpus room, and outdoor play area thus allows for all sorts of gradations of play, from the quiet table games appropriate to the living room upstairs, to the rough activities in the rumpus room, to construction and destruction projects in the covered play area, and then out into the really large-muscle type of running, jumping, etc. outside the house. This permits for a maximum of treatment flexibility and ability to divert a child to another area rather than suppress activity because it isn't appropriate to the particular place where it is being performed.

Returning to the front of the cottage, we find that the two main entrances open onto a driveway which curves in from the nearby road, passes before the doors, and curves back to rejoin the road. Across from this drive is a small squat structure which supports the end of the elevated upright of the "T". It functions as a sort of pillar, and contains some additional storage space for the ubiquitous bicycles and the heavy sort of camping equipment, items that flower into summer use and hibernate during the cold weather.

When the building was initially completed, it was something of a shock to the staff to find that so much of the wall area was made of glass. For instance, there are huge glass frames occupying much of the wall exposure in the dining room. This with a relatively untreated group would have been an invitation for vandalism—even with a group who had come along as far as our youngsters, it was a highly uncertain procedure. It is a tribute to the intensity of the staff work with them that a year and a half after their admission to this building there has been no major glass breaking incident.

PUBLICATIONS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

STANDARD REFERENCE WORKS

Diagnostic and Statistical Manual, Mental Disorders . . . prepared by the Committee on Nomenclature and Statistics of the American Psychiatric Association, 1952 . . . $2.00

Standards for Psychiatric Hospitals and Clinics, 1956 Edition (revised June 1958) for Public and Private Hospitals, Psychiatric Units in General Hospitals and Hospitals & Schools for the Mentally Defective . . . $1.00

An Outline for a Curriculum for Teaching Psychiatry in Medical Schools 25

SPECIAL CONFERENCE REPORTS

Psychiatry and Medical Education . . . Report of the 1951 Conference on Psychiatric Education held at Cornell University, organized and conducted by the A.P.A. and the Association of American Medical Colleges, 164 pp., cloth, 1952.

The Psychiatrist—His Training and Development . . . A substantive report of the 1952 Conference on Psychiatric Education, and a companion volume to "Psychiatry and Medical Education."

Special Price for both Reports . . . $2.00

Psychiatric Inpatient Treatment of Children . . . Based on the Conference on Inpatient Psychiatric Treatment of Children held October 17-21, 1956, in Washington, D. C. under the auspices of the A.P.A. and the American Academy of Child Psychiatry . . . $3.50

Design for Therapy . . . An investigation into the possibilities of collaboration between psychiatrists and architects in developing basic information for mental hospital design, construction, and equipment, 1952 . . . $1.25

The Volunteer and the Psychiatric Patient . . . A report of the Conference on Volunteer Services to Psychiatric Patients held June 12-17, 1958, in Chicago . . . $2.50

Psychodynamics 50

Summaries of Scientific Papers 115th Ann. Meeting . . . $2.50

Psychiatric Research Reports #1 — Pharmacologic Products Recently Introduced in the Treatment of Psychiatric Disorders . . . $2.00

Psychiatric Research Reports #2 — Approaches to The Study of Human Personality . . . $2.00

Psychiatric Research Reports #3 — Research in Psychosomatic Medicine . . . $2.00

Psychiatric Research Reports #4 — An Evaluation of The Newer Pharmacologic Agents and Their Role in Current Psychiatric Practice . . . $2.00

Psychiatric Research Reports #5 — Research Techniques in Schizophrenia . . . $2.00

Psychiatric Research Reports #6 — Application of basic science findings to psychiatric research . . . $2.00

Psychiatric Research Reports #7 — Stress; Experimental psychology; Child psychiatry . . . $2.00

Psychiatric Research Reports #8 — Research in Affects . . . $2.00

Psychiatric Research Reports #9 — Research in Psychiatry with Special Reference to Drug Therapy . . . $2.00

Psychiatric Research Reports #10 — Social Aspects of Psychiatry . . . $2.00

A Psychiatric Glossary — Paper Bound . . . $1.00

Library Bound . . . $2.00

Psychiatry, the Press & the Public 50

3 copies . . . $1.00

SPECIAL COMMITTEE & SURVEY REPORTS

Disaster Fatigue 35

Psychological First Aid in Community Disasters 35

Training Schools for Delinquent Children . . . A guide to planning with particular reference to clinical facilities, prepared by a special committee of the A.P.A., 1952 25

Psychiatric Nursing Consultation: Report of the Institute for Nursing Consultants in Psychiatry, 1954 50

Psychiatric Nursing Personnel — compiled by the nursing consultant to the Committee on Psychiatric Nursing of the A.P.A., 1950 60

PROCEEDINGS OF MENTAL HOSPITAL INSTITUTES

(Proceedings of 1949, 1950, 1951, 1952, 1953, and 1955 Institutes out of print)

The Psychiatric Hospital: A Community Resource (1954) . . . $2.00

Hospital Atmosphere as Treatment (1956) 50

Implications of the Open Hospital (1957) . . . $1.00

Proceedings of 10th Mental Hospital Inst. (1958) . . . $2.00

MISCELLANEOUS

Mental Hospitals (1855 Special Issue) 50

(10% discount for 20 copies or more)

The Evaluation of Therapeutic Agents, by Stewart Wolf, M.D. . . . $1.00

Principles, Skills and Tools of Scientific Management, by James L. Hayes . . . $1.00

Psychological Factors in Space Flight . . . By Capt. Norman Lee Barr, MC, USN; Lt. R. B. Voas, MSC, USN, and Lt. (j.g.) M. Yarczower, MSC, USNR . . . $1.00

Current Practices in Mental Hospital Administration . . . $2.00

Dedicatio Medici, by Dr. Francis Braceland . . . $1.00

Thirteen Indices—an aid in reviewing State Mental Health and Hospital Programs . . . $1.00

Recreational Trends in North American Mental Institutions, by Daniel Blain, M.D. & Pat Vosburgh 25

Portraits, by Dr. Clarence Farrar . . . $1.00

3 copies for . . . $2.00

Selected Reading Lists on Mental Hospitals, compiled by A.P.A. . . . $1.00

Psychiatric Architecture, a compendium prepared by the A.P.A. Architecture Study Project . . . $10.00

Order from:

AMERICAN PSYCHIATRIC ASSOCIATION

Publications Department

1700 18th Street, N. W. **Washington 9, D. C.**

Please send the publications checked above to:

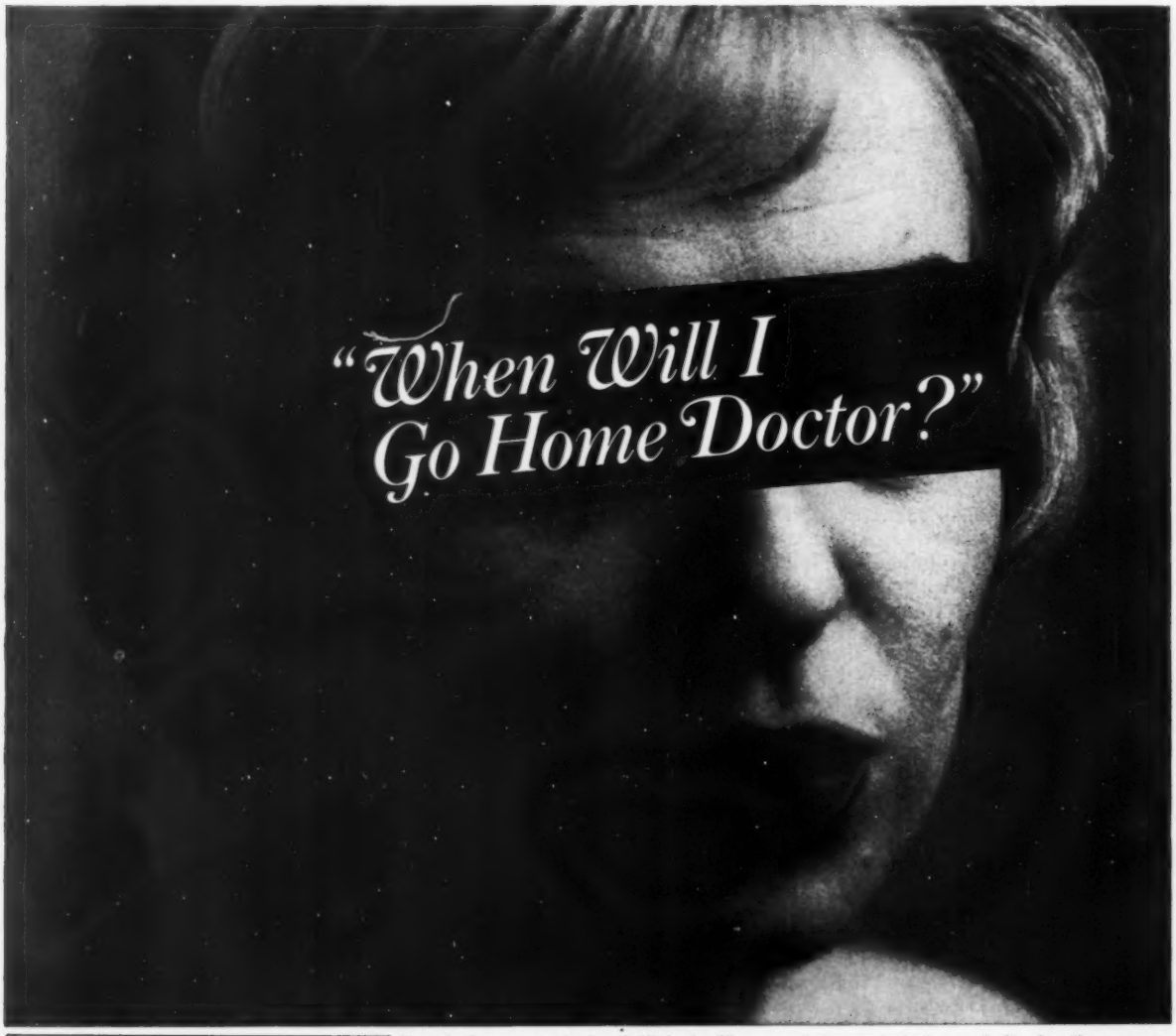
Name . . .

Address . . .

. . .

☐ Payment enclosed ☐ Bill me

The A.P.A. will assume shipping expenses via regular channels on all prepaid orders, except to countries abroad. If invoicing is necessary, a postage and handling charge of 25¢ will be added. Please allow at least 15 to 20 days for delivery.



YOUR ANSWER MAY BE "I DON'T KNOW" OR "VERY SOON." VESPRIN MAY MAKE THE DIFFERENCE

Vesprin is an agent of established efficacy and demonstrated superiority for the management of psychotic patients. In schizophrenia, manic states, and psychoses associated with organic brain disease, Vesprin controls intractable behavior patterns making patients more accessible to psychotherapy. Excitement, panic, delusions, hostile behavior are moderated to permit early insight for rapid progress into resocialization and rehabilitation. Not only is Vesprin your drug of choice for initial therapy, but it has proved effective in patients who failed to respond to other phenothiazines.

Vesprin does not oversedate your patients into sleepiness, apathy or lethargy — and drug-induced agitation is minimal.[1] It is relatively free from side effects.[1,2] Skin eruptions, photosensitivity or hyperthermia have rarely been reported. Individual dosage levels are easily established. Intramuscular injection causes no pain or tissue irritation. Vesprin often brings improvement in chronically disturbed patients refractory to shock therapies and other drugs.[3,4]

VESPRIN

SQUIBB TRIFLUPROMAZINE HYDROCHLORIDE

...a unique halogenated phenothiazine for the management of schizophrenia, manic states, psychoses associated with organic brain disease, senile psychoses, and primary behavior problems in children.

Dosage: Usual initial dose, 100 to 150 mg. daily, increased or decreased according to patient response. See literature. Supply: Tablets: 10, 25 and 50 mg., in bottles of 50 and 500. Capsules: 100 mg. in bottles of 50 and 500. Emulsion: 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). Parenteral Solution: 1 cc. multiple dose vial (20 mg./cc.) and 10 cc. multiple dose vial (10 mg./cc.). Vesprin Injection Unimatic (15 mg. in 0.75 cc.).

SQUIBB Squibb Quality — the Priceless Ingredient

"VESPRIN"® AND "UNIMATIC"® ARE SQUIBB TRADEMARKS

1. Goldman, D.: Am. J. M. Sc. 235:67 (Jan.) 1958. 2. Morehouse, W. G., and Freed, J. E.: Monographs on Therapy 3:32 (May) 1958. 3. Leger, Y.: Union Med. Canada 87:831 (July) 1958.
4. Bruckman, N. S.; Saunders, J. C., and Kline, N. S.: Monographs on Therapy 3:24 (May) 1958.

The Case For Activity Budgeting

By GEORGE R. SCHIEVE

Business Executive, Ypsilanti State Hospital, Michigan

HISTORICALLY, most state hospitals, like those in Michigan, have prepared budgets and been granted appropriations on a basis of past experience of the cost of various groups of items. Using the patient-day as a base, items or services are classified; that is, so much for clothing, food, supplies, fuel, salaries, wages, etc., per patient, per day. Frequently these were line item appropriations and were not transferable. As a result, most comparisons are necessarily made on a cost per patient per day basis, either between various periods at one hospital or between hospitals, rather than on the comparable cost of a service or activity for a given period or between similar units in different areas.

Because this kind of information is all that has been available, these budgets have been prepared based on accumulated information during past years on the same cost code basis. One obvious fallacy in this method is that certain expenses have only a limited relationship to the number of patients in a particular hospital. Such items as fuel, administration (to a degree), and other items usually classified as overhead, frequently are quite independent of the number of patients. Nor does variance in the size of the work load necessarily mean a *pro rata* increase or decrease in expenditures. Moreover, many groups or departments may use the same item but in varying amounts.

An administrator had, therefore, as his primary fiscal guide a set of figures showing expenditures as compared with allotments for specific classes of goods or services. This is admittedly basic and useful information, for adjustments can be made quickly and easily, if sometimes painfully, when this information is received. The obvious shortcomings are, however, the lack of any kind of performance data with which to guide adjustments, and the variety and number of departments that may be using a similar item. Unless detailed work is requested, the reason for a change in expenditure cannot be pinpointed, as the increase may be all in one particular area or it may be general and spread over many using departments.

Change-Over From Cost Code Method

This is the story of an attempt to change over from the cost code method of budget preparation to budgeting on an activity basis, the steps taken to make up such a document, and some conclusions on our part as to its value to the hospital and other agencies.

Many of the steps taken and procedures used in preparing an activity budget as reviewed here are similar to those recommended in the Hoover Report,* but of course on a much smaller scale. Such steps were taken prior to the writer's knowledge of the Hoover Report's detailed recommendations but were nevertheless based on similar reasoning.

"We recommend that the whole budgetary concept of the Federal Government should be re-fashioned by the adoption of a budget based on functions, activities and projects; this we designate as a performance budget."

As pointed out in the Hoover Report, the shift to an activity or performance budget does not change Legislative responsibility and that body still retains the power of limitation by appropriation. It is felt, however, that the accumulation of expenditure data by this new means will enable everyone concerned with budgeting to do a more effective job.

Pilot Studies Precede Program

For several years in Michigan there had been talk and behind-the-scenes work on this problem. It had been pointed out that time-consuming study was needed to isolate and develop the unit measurement factors which would be significant in determining the direction and level of future expenditures. Pilot cost accounting installations were made in representative institutions by the Accounting Division of the state government because it was believed that activity budgets based upon such measurement data would be of much greater value to the legislature in considering appropriations than the existing object code expenditure data. The concept of the activity budget basically means a focus of attention on the ends to be served and a constant scrutiny and evaluation of them rather than of the dollars to be spent.

First, since budget and accounting go hand-in-hand, there was the need for a different method of classifying charges and of coding them. Then came the formation and adoption of a plan of activities and programs for a stated period of time. Next, the program costs were related to resources; and finally, the authorized plan

---

**The Commentaries on Origin of the Executive Branch of the Government on Budgeting and Accounting, A report to Congress, U. S. Government Printing Office, Washington, D. C. 1949, p. 8.*

was followed according to a time schedule and at a cost within available resources.

Work was done to establish the activities on a functional basis and approximately 95 separate functions were established. (See table on page 36 for a breakdown of these activities. For reference, they were listed by title and number.)

System Based on Functional Organization

These functions, in many cases, crossed our conventional departmental lines. In other cases, smaller departments were combined under a single activity. The results of this functional organization became the basis for the future operation of the system. Extreme care was taken to establish only as many activities as were necessary. On the other hand, it was necessary to provide sufficient detail to obtain the necessary performance and cost data for administrative control.

We found that in our original breakdown some activities were too small to receive any charges, while others were so large that we later made subaccounts within one activity. Accounts were set up along this basis and were posted concurrently with the regular procedure for a period of less than one year prior to the attempt to prepare the activity budget request. Along with these new records came the recognition of need for its adaptation to reporting some kind of performance data. This was not very useful because in the beginning no one knew the significance of such data; there was nothing with which to compare it. However, month by month and year by year, it will grow more significant as comparisons can be made with previous months and trends can be seen in given areas.

At this point we concluded that, although we did not have too much in the way of experience data along these lines, we would make the attempt to design and formulate a budgetary request document. The form on page 36 shows what information was given. Undoubtedly, many revisions will be made but the basic principle of preparing a request by function can be shown with this form. By making additional sheets showing the summary of each series of activities, more information can be shown and finally, by making a grand sheet one may include much of the same summary information as that provided by the cost summary budget now in use.

In designing this form an attempt was made to furnish the more important information items that budget examiners and legislative committees usually expect, such as salaries and wages, food, and equipment. These classes show as items and the summary by classes is shown by subtotal and grand total. We also wanted to keep the present basic idea of showing cost figures for the prior year, the present year, and the request year. This points up any increase or decrease in the request. Because increases have always required detailed justification, we left space on each page for such justification and also to list the individual items of equipment that are being requested. On the back of the form we provided for the detail of personnel service showing a summary of each group of positions in each function and again detailing any increase and justifying it at the bottom of the page. By group of positions we mean the Civil Service title and level of positions. Thus, if one activity such as a kitchen has several cooks at the same level, they would be grouped together and the total for all such cooks shown. Any increase, however, even though the request might be for an additional employee in the same category, would be listed individually. Again, the summary sheets, by division and grand totals, show the costs of the request.

Undoubtedly, one revision that should be made in this form is to provide space for performance data. Such data would be of great use to both the local administration and those reviewing the document.

The next large job was to actually assign the almost 1,000 employees to the activity in which they worked. As was previously mentioned, many of these activities crossed our departmental organization lines. Also, many employees worked routinely in more than one activity. These we assigned by percentage after discussions with the employee or his department head. From time to time we expect to have to adjust these percentages as the emphasis shifts between activities. For example, a housekeeper might work in an office building where a variety of activities are located or a doctor might split his time between training, research, and service, with some community relations in addition. The difficulty then is to draw dividing lines to obtain the most useful information. One must decide if the total cost of medical staff is most needed or if it is more useful to obtain the total cost of the activity where these staff members may be working. Of course, such items could be posted both ways, duplicate records maintained and two reports written. In most agencies, however, there is not sufficient staff for such record keeping, so the decision has to be made as to which report is most useful in each area.

Distributed Expense Prorates Service Costs

Another task was to get all charges to the right activity with what has been called Distributed Expense. This prorates time and materials used by one activity in service to another. For example, the maintenance men's time in performing some service for another activity should be charged to the area getting the service, if the final report on the cost of such area or activity is to be complete. To accomplish this we designed a daily time and materials report for all maintenance men to send in each day. This report shows the area in which they worked and the materials that were used to accomplish such work. This information is then coded according to the activity code. This report has also been a useful tool for the maintenance supervisors and the administration in reviewing the work done by these departments.

In addition to the regular assignments of most employees and the time sheets of the maintenance men, we had one other problem as far as personnel is concerned. That was the temporary assignment of some employees away from their regular activity. Here we arbitrarily set eight hours as a dividing line. If such transfer was for less than one full day we ignore it; if for more than one day, we use a temporary transfer and the salaries are recoded. This transfer can be for either a fixed period or indefinite.

Here another decision had to be made in drawing a

line as to which employees' time should be distributed. In theory, all employees in a state hospital are taking care of patients, so it could be argued that we have only one basic activity. However, this defeats any attempt to develop any information for budget guidance. The extreme opposite in distributing expenses would be the prorating of everybody's salary and of all supplies, and requesting daily time reports from all employees. This would be an enormous task and the results would not be worth the effort. Somewhere between, then, is a happy medium and the decision has to be made on just which positions should be prorated. We included maintenance time, the time previously mentioned in the percentage breakdown, mileage, and telephone charges. We do not feel that these are all the charges that should be distributed but, until the system has been in use longer, we will distribute these and see if they are needed or if more should be added.

The above, then, takes care of personnel. The other charges are picked up in the accounting office, either from requisitions as they are filled by the warehouse, or from orders as they are written and completed. Again, some such orders for contractual service have to be charged to various activities as used, or by percentage. The telephone bill and car mileage, for instance, were actually as used by employees within a service and coded to charge the expense to their particular service. At this hospital all material goes through our warehouse, either in fact or on paper, so that these charges can be picked up from the requisition that takes the item out of the warehouse.

The next step was an attempt to prepare a budget request document based on the figures that had thus far been accumulated. Many problems developed here. Some charges, such as fuel, had never been assigned to proper users. Telephone and mileage charges divided among many activities had to be projected for a year in advance. It was decided that these details should be worked out as near as could be estimated and the document prepared, admitting the possibility of error the first year, but using it as a guide for the year to indicate its worth as an administrative tool.

All of the above will be of little value unless a system can be developed for accurately and rapidly reporting the information to both the administration and the using activity. This we contrived to do by reporting to each activity head his allowance in each category for the year and for each month of the year. The categories referred to are salaries and wages, food, fuel, supplies and materials, fixed charges, other contractual service, distributed expense, and equipment. Thus the supervisor knows in advance his allowance in each area and he receives a monthly report of the cost of his activity by these same categories.

Since this system has been in operation on a trial basis for only a few months, we have not had enough experience with it to make definite recommendations. One point has come up, however, and that is how to handle carry-over balances from month to month, be they debit or credit. We have concluded that a clearing account must be established, all balances transferred to it or repaid from it, and each activity started fresh each month. The main reason is that in some areas, due to unforeseen circumstances, some accounts will be overdrawn and there has to be a method of making this up. A secondary reason is that we do not feel it would be good policy to allow any one activity to accumulate money and bank it with the hope of a year-end splurge of one kind or another.

The advantages that are hoped for are numerous. First, by setting up secondary records and advising the department head or activity head of his allowance for a given period, we bring him into the budget and expense picture much more clearly and usefully. A department head will realize the over-all limitations placed on the institution and where his department fits into the picture. He will consider his requests in view of the allotment available and plan accordingly. A department head will also realize the necessity for advance planning so as to make his request in time to get it into a budget document, get it reviewed, and learn the results of the review. By using another reporting statement he can be advised of charges made against his activity on a periodic basis. He can be shown the cost of his activity in some detail and required to justify his request for expansions. This is where the performance data will be useful. If ten workers are shown to do certain amounts of work and the work load is greater than they can handle, what better justification can one give to a budget examiner or a legislative committee? The reverse can also be true. A department head can be shown that his request is not justified, based on the performance of his employees.

Another advantage to an administrator is that he will be able to show to budget examiners and legislators the actual planned program of the hospital in some detail, in terms that are easily understood. He can also show more clearly what results will come about if requests are reduced or denied, and in turn, should receive much better guidance from higher authority on program plans and/or areas of recommended reductions, if such are necessary.

Information Accumulates for Cost Studies

A third advantage that becomes apparent is the accumulation of information on which to base cost studies. Does it pay to run a dairy at the hospital? a bakery? a laundry? or should these services be contracted for with private companies? In the past, such information has not been readily available because all charges that should have been made against such activities were not made, and the various reports were incomplete and misleading. In order to accurately assess such problems, all expenses should be considered and those such as time of maintenance men or repair jobs, spare parts needed for machinery, fuel, and utilities, are sometimes overlooked.

A fourth advantage that is expected from this system is one that is extremely difficult to describe. Many times in a state hospital the employees are not too aware or concerned about the cost of operations of the hospital. In some ways this is all right, for the primary job of most employees is the care and treatment of patients and the concern about the how and wherefore of finances does not even enter their minds. In government work, how-

ever, the cost of such care is continually increasing, and more and more people are questioning the value returned from such increases. It seems only logical that everybody should know the cost of his particular operation and be ready to justify such cost.

Disadvantages should also be noted in so basic a change as this would be. The hospital administration would have to accept a new set of standards to be used in budgetary control. Unless more subaccounts were to be established within each activity, the various reports would be based on a new set of figures and some of the traditional guides would not be available. This would be true for all those involved with budget requests and controls as well as summary reports. If a budget examiner, for instance, or a legislator wanted to know the over-all cost of telephone service or mileage, such a budget would not provide this information.

A decision has to be made, therefore, as to which accumulation of information will prove to be the most useful. It is the feeling of the writer that the activity budget system would best fill all needs once it became accepted and familiar to those who have to make use of it. This system makes department heads in particular and employees in general more conscious of the need for economical operation within their own areas.

YPSILANTI STATE HOSPITAL

ACTIVITY BUDGET

Fiscal Year

Activity Account No.

	Prior Year	Current Year	Budget Request
Salaries and Wages			
Fixed Charges			
Other Contractual Service			
Food			
Fuel			
Other Supplies & Materials			
Distributed Expense			
Sub-Total			
Equipment			
Grand Total			
Justification for Increase:			

YPSILANTI STATE HOSPITAL

Activity Chart of Accounts

110 Superintendent's Office
120-1 Business Management
120-2 Accounting Office
130 Personnel Management
135 Community Relations
140-1 Reception & Information
140-2 Communication
150 Storage & Handling
155-1 Car & Bus Operating
155-2 Trucking & Hauling
160 Janitorial Service
199 General Administration

202 Medical Administration
205-1 Medical Staff Services—Regular
205-2 Medical Staff Services—Trainee
210 Acute Medical Service
220 Dental Care
222 Optometrical Service
224 Educational Therapy
225-1 Occupational Therapy—Craft
225-2 Occupational Therapy—Industrial
225-3 Occupational Therapy—Administration
226 Patient Work Training
227 Recreational Therapy
230 Physical Therapy
232 Religious Therapy
235 Psychology
240-1 Social Service—General
240-2 Social Service—Family Care
250 Outpatient Service
255 Medical Stenography & Medical Records

260 Pathological Department
263 EEG Department
265 Xray Department
270 Pharmacy
275 Research
290 Morgue & Burial

305 Nursing Service Administration
310-1 Nursing Service—A Women
310-2 Nursing Service—A Men
310-3 Nursing Service—B Women
310-4 Nursing Service—B Men
310-5 Nursing Service—C Women
310-6 Nursing Service—C Men
315 Psychiatric Affiliate Nurse Training
316 Attendant Nurse Training
320 Barber Shops
325 Beauty Parlor
330 Laundry
335 Patients' Clothing
340 Housekeeping & Janitorial Service
345 Transportation of Patients
350 Incoming Mail
405 Dietary Administration
410 Bakery
415 Butcher Shop
420 Vegetable & Fruit Preparation
440-1 A—Kitchen & Dining Room
440-2 B—Kitchen & Dining Rooms
440-3 C—Kitchen & Dining Rooms

505-1 Utilities Administration
505-2 Physical Plant Administration
510 Hospital Structural Maintenance

515 Power Plant Operation
520 Utility Service Facilities Maintenance
525-1 Care & Improvement of Grounds
525-2 Garden Production Expense
525-3 Garden & Grounds Administration
535 General Safety
540 Sewage Disposal
560 Carpentry & Cabinet Making
562 Masonry
564 Painting
566 Tinsmithing
568 Plumbing
572 Electrical
574 Refrigeration
576-1 General Mechanical
576-2 Maintenance Mechanical
578 Blacksmithing
580 Locksmithing
582 Automotive
590 Maintenance Shop
591 Tool Crib

605 Employee Housing
615 Employee Laundry
625 Employee Food Service
640 Other Employee Services
650 Employee Housing Structural Maintenance
655 Employee Housing Equipment Maintenance
660 Employee Housing Utility Service Facilities Maintenance
900 Farms Operation & Maintenance

Administrative Residencies

By T. A. BRAVOS,
Business Administrator, Sonoma State Hospital
Eldridge, California

THE NEED FOR TRAINED INDIVIDUALS in the field of hospital business administration, and the further need to recruit such professionally oriented people to mental hospitals are too obvious to call for discussion. Today's psychiatrist-administrator is well aware of these needs, but commensurate recognition of the need to establish qualifications and educational standards has been lacking.

Continued efforts on the part of California's state hospitals had resulted in the establishment by the Department of Mental Hygiene of a category of "student professional assistant," one of whom was to be assigned to business administration. With the approval of the superintendent of our hospital, discussions were held with the educators responsible for the program in hospital administration in the School of Public Health at the University of California. Classifications, salaries and related problems were discussed and ultimately approved by the necessary state agencies. With the university, we then established at Sonoma a preceptor-student relationship which brings in "administrative residents" to work on a full-time or part-time basis.

The university's graduate program in hospital administration currently takes three years. The first year is one of internship in a selected hospital; this is followed by a year covering all academic requirements at the university, and by a further year in residency with a selected preceptor in a hospital. On completion of this training, the resident is ready to begin his career in the general field of hospital administration.

Prior to our present arrangement there had been virtually no liaison between the state psychiatric hospitals and the university, despite the fact that the university program had been in existence for some years. Not unnaturally, little or no consideration was given by university or students to job opportunities in psychiatric hospitals.

Today, although the university's curriculum is basically oriented to general hospitals, there is increasing interest in the psychiatric hospital as the need for more trained people becomes apparent. The university includes a three-hour seminar on business administration in psychiatric hospitals, and a full-day session is devoted to a field trip, when the class comes to Sonoma for a clinical and administrative review of the program, with a tour of the hospital's physical facilities and services. As a result, several able and qualified men have been recruited for top level and middle management positions within the state hospital system.

We have now been receiving administrative residents for five years, and find that their value to the hospital is not illusory. The trained and inquiring mind of the student provides a constant incentive to both medical and administrative staff members, inviting them to approach administrative problems effectively.

One administrative resident gathered and analytically screened material on the school program for patients, and this work was utilized in extending the program scope when an addition was made to the school. Another discovered, in reviewing the food services, that the plate waste on certain wards was extremely high. His objective was to determine how excessive garbage was related to food production, to distribution, and to direct service to the patient, and what steps should be taken to correlate food production and service so as to reduce garbage to a reasonable minimum. The results of his study were informative to both the administrative and clinical services of the hospital.

Special Studies by Administrative Residents

The enormous amount of planning detail usually associated with the building of a new ward or medical office building does not permit members of the management team to devote sufficient time with each department to insure a completely integrated and well-planned office layout. We used the services of one of our administrative residents, working directly with top management, to provide the necessary consultative link. The resident was given enough time to develop overlays, work with department heads on precise functional needs and relationships to other departments, create a work flow pattern and resolve other details. This information, presented in composite form to the architect, resulted in far more effective planning and minimal changes when the contract was let to a work order.

Another administrative resident made a study to determine the placement success of the graduates from the hospital's school. He was able to furnish factual data as to what happened to the school graduates for the period 1947-1954, and this information furthered sound master planning for the school building program. The resident himself benefited because this project enabled him to work with various departments of the hospital, particularly in the clinical areas.

In a recently developed management analysis of the state hospitals, it was recommended that administrative assistance on the staff level be provided for each medical superintendent. The establishment of this position opens another career opportunity in state hospitals.

A hospital seeking to establish an administrative residency program must realize that the inauguration of the program requires time for planning, directing and evaluating; no hospital should undertake teaching in this or any other field without the necessary facilities and personnel. But the value of such a program is incalculable.

A score of universities throughout the nation now feature specialized programs in hospital and public health administration, offering degrees in designated related fields. Have you explored the possibilities of using these resources to develop modern management techniques in your hospital?

Developing A Procedures Manual*

By JERRY C. BOSWORTH,
Student Institution Management Trainee
Caro State Hospital for Epileptics, Michigan

If policies and their implementing procedures are to be effective, they must be known to the personnel concerned. Manuals are written because agreements and understandings about what should be done, when, why, and by whom tend to become vague and ephemeral with personnel turnover and the passage of time unless they are recorded in clear, concise form and are accessible for handy reference.

Because of the wide variety of purposes for which manuals are contemplated, there is no single, "best" technique of manual writing which is equally appropriate for every situation. Some similarity, however, undoubtedly underlies the diversities and my purpose is to describe and explain the pattern of development which I found helpful in writing a procedures manual for the personnel office.

At first glance the development of a policy and procedures manual seems to be a mammoth undertaking, requiring special skill and overwhelming effort. The biggest step has already been taken, however, once management has determined the policies and procedures which are to guide the organization's program.

This was the situation at Caro State Hospital in the summer of 1958. The vital need for a written guide to procedures was demonstrated when a new personnel officer was trying to become acquainted with procedures in the personnel office without the assistance of the secretary, who was on sick leave, and without the information that a procedures manual would have provided. The value of written policy and procedure manuals in the orientation and indoctrination of new personnel was vividly illustrated! It was as a result of this event that I was given the opportunity to compile a procedures manual for the personnel office.

Top Management Backs Full-Time Job

I was fortunate in finding the two most essential elements to the successful development of this manual. The first was the complete backing of top management, since only with this full support could adequate facilities and complete access to information be obtained. The second was that the development of the manual was considered a full-time job. This latter makes all the difference between a coherent, complete manual and an incomplete or disjointed one. It is essential that the cumulative process of gathering, sifting and assimilating information not be interrupted by more "immediate" chores.

Complete Guide Includes Policies As Well As Procedures

In the beginning it was believed that a description of the procedures involved in conducting the hospital's personnel transactions would suffice. It soon became evident, however, that a complete guide to personnel transactions under the Civil Service system should also state the policies which the procedures had been designed to implement. The basic question "why" must be answered before the procedural questions—what, when, and by whom—can be answered.

Clear definition of the manual's scope is itself a giant step toward its completion. A survey of the available information and of the needs to be met must be made before the scope and limits can be defined. This survey may even precede the decision to write a manual, but in any case the subjects to be covered will have to be determined before any clear notion can be formed of how much research and writing will be required.

Most Important Topics First

Before the actual writing begins, all the topics to be covered should be ranked in order of their need for clarification. The two or three most important ones can then be selected for immediate attention. A word of caution: each topic taken up should be small enough to be susceptible to concentrated development and completion before turning to the next topic. In my own case, for instance, there was general consensus that the topic of personnel appointments should be dealt with first, and the topic of positions classification last, because the former was more complex and constituted a much greater part of the office's daily work load.

Having decided to write the section on appointments first, I consulted the appropriate people in the Civil Service Department in Lansing for suggestions,

---

* *A copy of this manual is available from the M.H.S. Loan Library.* *See Page 47.*

and collected policy letters, training manuals, Civil Service Commission rulings, sample forms, and any other information which seemed pertinent. I was then ready for the solitary work of sifting and synthesizing and completely writing the first draft of the manual's section on appointments. The first chapters were the most difficult and the experience gained in writing them helped to expedite the completion of the remaining chapters.

It is during the processes of research and writing that the central importance of "full support of management, and adequate facilities" is realized. My office was secluded and equipped with a desk, bookshelves, and a typewriter. I was able to concentrate and work efficiently. Another very significant aid was the availability of stenographic assistance for the typing of my rough drafts. The whole environment facilitated expeditious and uninterrupted concentration on the manual's completion.

Manual Not Technical

Writing of policies and procedures need not be technical, nor should it require the use of a special format. The format which I used divided the discussion of Civil Service employment into nine chapters, each topic being discussed in chronological sequence, i.e., the certification and appointment of a candidate to fill a vacant position in the state classified service, the employee's conditions of employment, and the employee's separation from the state service.

The various aspects of each of the transactions described in the manual were discussed in the following order:

1. A statement of the rule (or rules) of the Civil Service Commission which sets forth the basic action to be taken or refrained from.
2. An explanation of the policies which have been developed to implement the rules.
3. A description of the specific procedures to be followed in accordance with formally established policies.

The pages of the manual were not numbered. Consequently, it can be revised without destroying the accuracy of the table of contents, which was designed to provide a single index to the manual's contents. I included a glossary of terms and three appendices which provide the reference material (specimen procedure sheets and examples) needed to elaborate and illustrate the text.

If the purposes of a manual are to clarify and not to confuse, to bring order out of chaos, and to serve as a handy reference document, its use should require little training or interpretation. The writing must be readable (lucid, comprehensible, and appealing); its layout should be simple; and it should be housed in a binder which facilitates ready access to its contents.

Useful Manual Must Lend Itself to Revision

The job of policy and procedural development is never completed in a program of any complexity of size. If, therefore, a manual is to continue to provide maximum utility, it must be revised from time to time as policies or procedures are changed.

NEW STELAZINE* EFFECTIVE IN
RE

IN CHRONIC PSYCHOTIC PATIENTS REFRACTORY TO OTHER THERAPIES

"It is obvious that we have in ['Stelazine'] a very effective drug which often produces results where other treatment has failed."

Gunn, D.R.: The Role of Trifluoperazine in the Treatment of Refractory Mental Patients, in Trifluoperazine: Clinical and Pharmacological Aspects, Philadelphia, Lea & Febiger, 1958, pp. 47-53.

"... the majority of patients treated—formerly considered practically hopeless—are now in some way more easily managed on the ward."

Klimczynski, J.J.J.T.: Treatment of Chronically Ill Psychotic Patients with Trifluoperazine: A Preliminary Report, *ibid.*, pp. 101-112.

"The relatively low number of failures of treatment, even in those who have been sick for a long time, must be considered almost as significant as the high proportion of good recoveries."

Goldman, D.: Clinical Experience with Trifluoperazine: Treatment of Psychotic States, *ibid.*, pp. 71-86.

Available: Tablets, 2 mg., 5 mg. and 10 mg.
Multiple dose vials, 10 cc. (2 mg./cc.)

Literature available on request.

Smith Kline & French Laboratories (SKF) **leaders in psychopharmacology**

*Trademark for trifluoperazine, S.K.F. (10-[3-(1-methyl-4-piperazinyl)-propyl]-2-trifluoromethylphenothiazine)

READERS' FORUM

Engineers and Building Problems

In reading the February issue consisting of the Institute proceedings, I was particularly interested in the article on "Adaptation of Old Buildings to New Needs."

Most of the comments were by heads of institutions and such over-all authorities on the subject as were available. It seems to me that there is much more good information obtainable from the little man in the field than is recognized.

In many instances, the superintendent of an institution is exceptional in his field of psychiatry and medicine, but very poor in his over-all understanding of the mechanical and electronic and structural phases or functions of the institution.

An architect loves to design and create outstanding structures, and means well when he specifies certain types of heating, plumbing, or electrical facilities. But he does not have to maintain these various essentials and, therefore, may hand the institution multiple problems.

Too often suggestions from the hospital engineers are not even asked, and, if they are asked, attention is not paid if the particular suggestion is practical rather than pleasing to the eye.

Remedies and solutions to existing problems are usually solved in the field, and usually after a study by the engineer or some of his co-workers. These problems might not even have originated had he been consulted to a minor degree in the beginning.

I note there are quite a few meetings of various types on the quarterly calendar, yet there are none for mental hospital engineers, in spite of the fact that this is fast becoming recognized as a profession in its own right.

The hospital engineers from the state-owned and operated institutions in Kansas have organized into a group known as "Kansas State Maintenance Engineers Association." The reason for the organization, formed with the sanction of the Director of Institutions, is the recognized need of coordination and education among the engineers. To my knowledge, this is the first organization of its kind in any state. We are not affiliated with any other hospital organization.

O. D. Ewing, Maintenance Engineer, Winfield State Hospital and Training Center, Kansas

Psychiatry in Korea

In Korea, as you may be able to guess, psychiatry is not well developed. We feel we have to make a great effort to build it up. We have not a single national mental hospital for the 25 million people. We organized the Korean Psychiatric Association last year. It has only about 40 members who mostly had no proper training, and not all of them are medical doctors. We need psychiatric literature published in the U.S., but we have no way to obtain it because of the difficulty in sending money. I think the publications you sent may be very useful for me. (A year's complimentary subscription to MENTAL HOSPITALS plus other literature have been sent to Drs. Ro and Osamu Kan (See next page).

I am treating over 40 patients myself alone at the Korean Naval Hospital in Chinhae. At present, because of lack of other facilities, I use psychotherapy only. I do not have even E.C.T. equipment. Tranquilizers and other drugs are not available. Psychotherapy is very difficult because most of the patients are so ignorant that they cannot express correctly their feelings and thoughts. They usually complain of headaches and some other somatic complaints. Therefore my therapy has to be somewhat like a school education.

Another difficulty comes from our cultural difference from that of U.S. The underlying mechanism may be the same but the color of the symptoms is quite different and it is hard to analyze them. I believe that, in a psychiatric condition, the invisible cultural setting and visible physical setting are both important etiologic factors, and they are reciprocal. In an individual patient, the psychic and somatic phenomena may be happening at the same time and separately. But in the treatment I think we can influence them from either side—psychology or physiology.

Dr. Ro Chae-Song, Chinhae Naval Hospital, Chinhae, Korea

"Psychiatry Spreading Itself Too Thin?"

Your open invitation for commentaries on articles appearing in MENTAL HOSPITALS tempts those who endeavor to keep up with their reading and do a day's work besides, to pause and delay the bed hour for reflections. Psychiatrists in institutional practice are imposed upon, belabored and bamboozled by much that passes for "new," as if past experience and common sense should be totally discounted. For my part, there is more food for thought in the articles of Doctors Whatsisname and Freyhan than in the rest of the January issue of your publication. Of course, the other articles do serve some useful purpose.

Psychiatrists are recognized vendors of words and ideas. We are often berated for want of scientific validity in our efforts, and patients suffer for want of realistic concepts. Is there meaning in the endless varieties of "therapy," rehabilitation approaches and designs for operational systems? What of the Holy Cow, the "team approach," and rehabilitation programs that assume that a recovering patient is emerging from a cocoon and must be taught to fly?

There is no substitute for trained practical judgment and the undefinable human equation when faced with a problem. Mental patients, as others, faced with the problem of living and survival, require the fullest consideration of the attending physician with all the resources at his command. All ancillary services should be subordinated to this effort. Results will be no better than the capabilities of the man at the helm and the extent of cooperative efforts from subordinates. Such thoughts were stimulated by recent articles in your journal. The sad speculations by Dr. Adams and Mrs. Hedman in the January issue are merely public cleansings to be dealt with more privately. The review articles of the Tenth Mental Hospital Institute in the February issue are healthy airings, not to be mistaken for final answers.

During a recent symposium on pharmacotherapy, Aldous Huxley reminded medical scientists that "Thanks to these new drugs, the dictators of the future will have no need to bully man into obedience and conformity. They will get men to love their servitude." At the same meeting a researcher claimed great success for the tranquilizers. A more conservative physician suggested that many other factors may be playing a role in promoting higher discharge rates. I might add that not the least of these is a too liberal policy in turning unrecovered patients back to the community.

Scope Weekly, an Upjohn publication, cites the Joint Commission on Mental Illness and Health as estimating, at a minimum, 17,500,000 individuals in the United States with "nervous and mental illness of sufficient severity to warrant treatment." This figure exceeds any previous official estimates. One may wonder how many cases are currently developing from fashion, *folie à deux*, high pressure salesmanship, and promises which should *not* be realized for the good of mankind.

Psychiatry seems to be spreading too thin to cover its recognized limitations. It is giving comfort and support to pseudo-therapists of questionable competency and scruples who speak too soon and promise too much. The rash of ill-conceived "educational" publicity on techniques and cures in the press, on the radio and television under commercial sponsorship invites discredit of legitimate claims. Unqualified persons are having a lucrative heyday with private "psychotherapeutic practices." Unfortunately, the conservative, dependable leadership of our speciality holds silent. To promise to rid our world of mental diseases is gratuitous, unrealistic and unattractive. No other professional group has ever envisioned such an undertaking. Psychiatrists have not been "called" to form the vanguard of a crusade to rid the world of behavioral disorders due to attritions of living and the unkindnesses of nature.

S. J. Tillim, M.D., Supt., State Hospital, Reno, Nevada

Japanese Psychiatrist Seeks Help

I was the president of the Kanagawa Prefectural Mental Hospital "Kinkoin" Yokohama when Dr. Daniel Blain visited Japan several years ago. He gave me much valuable advice with regard to the treatment of mental illness and the architecture of mental hospitals. He told me of the total push threapy which was quite new to me.

Encouraged by this, I attempted to rebuild the hospital and reorganize the system of treatment. The old isolation rooms were entirely rebuilt and new comfortable rooms were made. I tried to have the very disturbed patients receive occupational therapy and recreation as early as possible, instead of locking them in the rooms.

I also endeavored to develop the total push therapy. Occupational therapy, recreation and milieu therapy were introduced in addition to specific medical therapies. For this purpose, I reorganized the nursing section by appointing specialized personnel in charge of each activity.

Furthermore, we tried hard to introduce these ideas in all the mental hospitals of Japan. We are glad to say that new buildings based upon these ideas have been or are going to be built all over the country, although in my opinion, there are not enough. Many chronic patients who were entirely forgotten in the corners of the rooms are now drawing the attentions of physicians and nurses, and occupational therapy and recreation are undertaken more actively in advanced hospitals.

Last April a national institution for mentally retarded children was established as the first such governmental organization in Japan. Fortunately or unfortunately, I was recommended to be the first president of this institution, because it was required that this position should be occupied by a psychiatrist.

The etiologies, treatments and prevention of feeblemindedness are mostly beyond our knowledge. Therefore, after devoting more than 30 years of my life to the problems of psychosis, I come back to the starting line of my new life to serve the feebleminded.

The National Institution for Retarded Children named "Kokuritsu Chichibu-Gakuen" is located at Tokorozawa-shi, Saitama-ken. This institution is to accommodate the severely retarded children as well as other handicapped children from all over Japan. I would be grateful for any advice from America on how to advance the development of this institution.

Osamu Kan, M.D. President, Kokuritsu Chichibu-Gakuen

BOOK REVIEWS

PSYCHOPATHIC PERSONALITY AND NEUROSIS—A. A. A. Terruwe, M.D., translated by Conrad W. Baars, M.D., P. J. Kenedy & Sons, New York 8, N. Y. $3.50

In a strikingly original work that has aroused considerable controversy in Europe, a Dutch psychiatrist discusses the different forms of non-psychotic mental disorders and their implications in pastoral and counseling work. An analysis of the psychopathic personality, including a number of case histories, is followed by detailed suggestions for the guidance of psychopaths and stresses the point that the spiritual director and counselor are limited to intelligent guidance which cannot influence the disorder itself.

Dr. Terruwe then goes into the nature of neurosis and the origin of repression, discusses the basic scientific truths of Freudian psychoanalysis as well as its philosophical errors, and offers her own explanation based on rational psychology.

The author distinguishes between various clinical forms of neuroses, illustrating them with many examples, and points out the necessity for close cooperation between the psychiatrist and spiritual director. She is aware of dangers that may arise in counseling neurotics, and does not hesitate to discuss these from the viewpoint of both patient and director. The guiding principles that she sets forth provide invaluable reference for spiritual directors, and her work as a whole offers a stimulating challenge to those engaged in psychiatric or counseling work.

A second book by this author, *The Neurosis in the Light of Rational Psychology*, will be published in the near future. Here Dr. Terruwe discusses theory and treatment in great detail, and outlines two newly discovered clinical forms of the neurosis, the "energy neurosis" and the "fear neurosis camouflaged by energy." Practising psychiatrists, analysts, psychologists and others working with the mentally ill will find this a most stimulating and revealing book.

C. W. BAARS, M.D.

SOCIAL PSYCHIATRY IN ACTION—Harry A. Wilmer, M.D., Ph.D. Charles C. Thomas, Springfield, Illinois. 1948

This is the story of a therapeutic community operated for 10 months by the author on the admission ward of the psychiatric treatment center at the U. S. Naval Hospital, Oakland, California.

The admission ward was a 34-bed locked ward. About a hundred male Navy and Marine patients were admitted each month and the average length of stay was about ten days. Almost half the patients were schizophrenics (45%), 27% were psychoneurotics and 28% had character and personality disorders.

Six days a week, Dr. Wilmer conducted a daily 45-minute community meeting for all patients and staff. This was followed by a staff meeting where the community meeting was discussed and analyzed. The rest of the patients' program was not unlike a usual psychiatric ward program including patient activities and work assignments. Dr. Wilmer saw each patient initially for evaluation. Patients could ask to see the doctor at any time and were seen in turn. One patient was usually seen for continuing psychotherapy while on the admission ward, both for therapy and to provide Dr. Wilmer and staff with additional feedback from the patient community.

The ward was staffed in a usual manner for a Navy psychiatric ward and no training was provided for nurses or corpsmen other than that available through attendance at community meetings and staff meetings. A few corpsmen had received training at the Navy psychiatric technician school. There was one psychiatrist, one research psychologist and a part-time social worker.

The results of this program showed that for the ten month period not a single restraint was applied, not a single patient was placed in seclusion, and only negligible use was made of barbiturates. A small number of hyperactive psychotic patients received ataractic drugs and an occasional patient was sent to another ward for electric shock therapy.

This was not an attempt to "cure" patients. This was an experiment designed to show that psychiatric patients, no matter how disturbed and psychotic (and from Dr. Wilmer's descriptions, his patients could match any seen in a civilian psychiatric ward), could be managed by social pressures and attitudes rather than by drug or mechanical restraint. In this, he seems to have been eminently successful.

Dr. Wilmer kept extensive and complete notes of every community meeting and the staff meeting that followed. Tape recordings and movies were also made. About half the book is devoted to verbatim accounts of these meetings, which illustrate vividly the interactions between the various people who lived and worked on the ward. These accounts also show the progression of isolated episodes which illustrate points of technique in operating a therapeutic community, such as dealing with one patient who dominates the meeting, or a hostile subgroup, or with violent or delusional behavior of patients or such themes as suicide.

The theoretical basis for this therapeutic community was the provision of a ward atmosphere and staff attitudes that permitted and fostered successful repression of emotional conflict while at the same time opening through social measures channels which permitted the venting of anxiety and assisted patients in dealing with their anxieties. However, before this could happen, staff had to learn to be aware of, tolerate and deal with their own anxieties. Dr. Wilmer emphasizes time and again the need to see patients as human beings with dignity and self-respect and the multitudinous ways that this can be conveyed to the patient in everyday dealings with him.

Mr. Gregory Bateson, an ethnologist who visited the ward for a week, writes a chapter concerning his observations. He points out that the fact that this experiment was conducted in a military establishment has significance. The members who participated here were all part of the same organization with status, roles and authority determined by established hierarchy. Further, the experiment which sought to bring people together to deal

with their problems was an extension of Navy tradition where orderly cooperation between individuals is essential to successful military operations. Mr. Bateson believes that the experiment is replicable providing proper leaders are found—and the minimum requirements for these leaders are "affective integrity and a belief that this integrity will permit the identification of self in others." (p. 349).

Social Psychiatry in Action seems basically to be the moral treatment of the nineteenth century brought up to date in line with modern psychiaric and social theory. The book is essentially a personal account of what happened to Dr. Wilmer, the staff and the patients. It is written in an easily-read style that at times reads like a story rather than a scientific text. A bibliography is included of more than 300 titles dealing with group therapy and therapeutic communities.

Psychiatrists, nurses, aides, students—in fact everyone who deals with psychiatric patients can read this book with profit if only to learn that it is possible to manage any kind of psychiatric patient without mechanical restraint and with limited application of drugs, and to see that patients can act like people if they are treated like people and expected to act like people.

PATIENTS, PHYSICIANS AND ILLNESS, Sourcebook in Behavioral Science and Medicine, edited by E. Gartly Jaco. The Free Press, Glencoe, Illinois, 1958.

This is a compilation of 55 relatively brief papers dealing with sociological and anthropological aspects of medicine and medical practice. The book encompasses a wide range of subjects. There is a group of papers describing the "professionalization" process that occurs to the medical student in becoming a physician; papers that deal with social and personal components of illness as socio-economic aspects and epidemiologic considerations, health practices and attitudes among minority groups, community organization for health, etc. The papers are easily read and are of general information and interest.

There are two papers in this book which hold special pertinence for those concerned with psychiatric hospitals. One is Definitions of Health and Illness in the Light of American Values and Social Structure by Talcott Parsons (p. 165). The other is Illness, Therapy and the Modern Urban American Family by Talcott Parsons and Renee Fox (p. 234).

These papers, and the first is primarily in reference to mental health, look at illness and health in terms of role-performance and ability to carry out tasks in a framework of social systems and institutions set up by the society. Health is defined as a state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized. Illness then implies a disturbance of the individual's capacity in task and role performance. In the values of American society, illness is considered to be beyond one's control, illness exempts one from usual role and task performance, illness is a legitimate state and illness implies that the sick person and his family have an obligation to seek competent help and to cooperate in

the therapeutic process. Parsons draws attention to how the patterning of illness in our society relates to the problem of directions of deviant behavior and to selective emphasis among the social components involved in the therapeutic process.

The second paper describes relationships between illness and the family through combining sociological analyses of the structure of role-systems with psychodynamic analysis of certain personality processes. Illness is here considered both a psychological disturbance and a deviant social role. The role of the family in illness is considered —that in our culture, the sick have tended to be pushed out of the home, that the sick role permits the deviance of illness to be medically controlled and that the therapeutic process is facilitated in the extra-familial setting.

In recent years the mental hospital has been under scrutiny as a social institution and system. In more recent years some mental illnesses have been looked at as phenomena of intra-familial interaction. These two papers extend the dimensions of current thinking and may hold theoretical implications for therapeutic social interventions.

SUMMARY OF SEMINARS FOR G. P.'s

The Carrier Clinic, Belle Mead, New Jersey, has completed its second annual series of Seminars of Psychiatry for the General Practitioner. An average of 111 physicians from Pennsylvania and New Jersey attended, of whom 75 were members of the American Academy of General Practice which gave 18 hours of Category I credit for attendance at the series.

There were 12 lectures by eminently-known psychiatrists and neurologists, (E. Caveny, J. Ewalt, D. Farnsworth, F. Forster, R. Heath, C. Ham, E. Busse, M. Guttmacher, W. Malamud, H. Brosin, H. Tompkins, H. Carmichael), on topics especially selected to answer needs of the general practitioner. Among the topics discussed were interviewing techniques, office management of the neurotic patient, the physician's use of himself, chronic dependency, neurotic reactions in the aged, etc.

Each lecture has been summarized in two pages in an attractive and easily-read small pamphlet which is available on request from the Carrier Clinic. The pamphlet would be useful to those planning educational programs for general practitioners.

LUCY D. OZARIN, M.D.

NEW PRODUCTS

VINYL WALL PANELS

Heat and humidity had caused the plaster to flake off the walls of one of our large shower rooms. We had to find a wall covering that would withstand these conditions. Ceramic tiling was an obvious answer, but our search turned up something considerably less expensive.

Clad-Rex vinyl panels were installed and so far have proved very satisfactory. They are 4 by 8 foot aluminum panels with a veneer of vinyl, available in many colors and textures. A contact cement is used to attach them to the wall, and we haven't had any trouble with their being loosened by heat, steam or dampness. The finish seems to resist stains and marks; it can be wiped clean with a damp cloth.

The panels are made by the Clad-Rex Corporation, 2101 S. Indiana Ave., Chicago 16, Ill., which is a subsidiary of the Simoniz Company. Among the finishes available are wood, leather and textile effects; the backing can be had in either aluminum or steel. We used an aqua-green linen pattern on aluminum in the shower room, and the cost came to 60 cents a square foot.

Paneling of this type would be ideal for large areas of unbroken wall with accurate dimensions, and would certainly be a great improvement in appearance over the "surgery room" tile which lines so many hospital corridors. The panels do have one major disadvantage; they are hard to install around corners and where considerable bending or cutting is necessary.

Several new products have come to my attention which are worth noting although we haven't yet tested them. One is the Scots Guard fire alarm. No wiring is needed because the apparatus is spring wound. It might, therefore, be useful for older buildings, particularly as an interim precaution for areas that do not yet have a sprinkler system. The manufacturer says that the Scots Guard operates by a coil thermostat that rings a loud alarm when the room temperature gets to around 130°F. The device costs $9.95 and is available from Crusader Sales, Box 1191, Bristol, Conn.

AUTOMATIC INSECTICIDE DISPENSER

Huntington Laboratories Inc. of Philadelphia (Hospital Division: Huntington, Ind.) has brought out an automatic aerosol system for dispensing its Done Died insecticide. The wall-mounted sprayer, which is electrically operated, automatically activates a metered can of Done Died every 15 minutes, releasing a 100 mg. shot of the insecticide each time. Done Died is said to eliminate flies, ants, mosquitoes, gnats and other insects but is non-toxic to humans. A 12-ounce can contains 3300 shots, enough to last 34 days on a round-the-clock basis. Each sprayer is effective for about 6,000 cubic feet of space. The stainless steel dispensers cost $26.00 apiece and the 12-ounce cans of Done Died run $4.35 each, six for $25.80, or $51.00 a dozen . . . all prices f.o.b. Philadelphia or Huntington.

PORTABLE PICNIC TABLE

A portable picnic table that might be useful for outdoor recreation areas is made by the Haldeman Homme Mfg. Co. (2580 University Ave., St. Paul 14, Minn.) The redwood table with two benches attached measures 8 feet in length and seats 8 adults or 12 children. Two more persons can be accommodated by placing a chair at each end. The understructure is made of 16-gauge one-inch seamless steel tubing. The bench supports are flat on the ground so they can be easily stepped over. A pair of 10-inch rubber-tired wheels is attached for wheeling the folded table from place to place. Folded, the unit measures 21 inches wide, 69 inches high and 51 inches deep. List price is $68.75 f.o.b. St. Paul; shipping weight is 170 lbs.

ALEXIS TARUMIANZ

Eleventh Mental Hospital Institute Follows New Format

In an endeavor to overcome the increasing difficulty of obtaining wide audience participation, the Program Committee and the Medical Director have devised a new experimental format for the Eleventh Mental Hospital Institute to be held October 19 through 22, 1959 at the Statler Hotel, Buffalo, New York.

First Day—Monday, October 19

1:30 p.m. Special Sectional Meetings. Notice so far has been received of the following: State Commissioners; Hospital Business Managers; Directors of Volunteers; Psychiatric Nurses.

5:30 p.m. "Early Bird" Party, to enable members of the Institute to renew old acquaintance. Beer and pretzels will be provided, and there will be a Dutch Treat bar for other drinks.

6:30 p.m. Orientation Meeting for *all* discussion leaders. A special notice will be sent out to these individuals immediately before the Institute. Also present will be the Medical Director and staff, members of the Program Committee, and the Local Arrangements Committee Chairmen.

Second Day—Tuesday, October 20

9:00 a.m. Plenary Session. There will be a half-hour Presidential Address by Dr. William Malamud, followed by a keynote speech on the Institute's main topic: THE PSYCHIATRIC PROBLEMS OF THE AGING AND OF THE AGING MENTAL DEFECTIVE, by Dr. Leo Bartemeier, the Discussion Leader.

11:30 a.m. The Institute membership will divide itself into one large Main Group (about 350 people) and several small Pilot Groups of eight or ten pre-selected people (total about 150), the personnel of which will remain constant throughout the Institute. Each of these Pilot Groups will proceed to its assigned room for the opening of its deliberations.

12:00 noon. Lunch for Main Group.

1:00 p.m.-4:00 p.m. Main Group will reconvene to discuss the topic on aging, with a mid-afternoon break at 2:30 p.m.

6:30 p.m. Cocktails

7:00 p.m. Dinner

8:00 p.m. Academic Lecture: Lecturer to be announced.

Throughout Tuesday afternoon and all day Wednesday, the Pilot Groups will devote all their time to the discussion of the main topic—"The Psychiatric Problems of the Aging and of the Aging Mental Defective." A light luncheon will be served daily in each meeting room. The Pilot Groups will not rejoin the Main Group—except for the cocktail party, Annual Dinner and Academic Lecture on Tuesday night—until Thursday at 9:00 a.m., when selected people from the Pilot Groups will present reports on their deliberations for discussion in full Plenary Session.

Third Day—Wednesday, October 21

(Main Group Only. The Pilot Groups will remain cloistered.)

9:00 a.m. LIBERALIZATION OF THE CARE OF THE MENTALLY ILL AND THE MENTALLY DEFECTIVE: Keynote speech by Dr. Robert E. Bennett, the Discussion Leader. This topic will be discussed until noon, with a mid-morning break at 10:30 a.m.

12:00 noon. Lunch

1:00-4:00 p.m. Five Simultaneous Sessions, with mid-afternoon break at 2:30 p.m.

TOPIC A. THE MEDICAL AUDIT: Dr. Lee Sewall, Perry Point, Maryland.

TOPIC B. ROLES OF THE PSYCHOLOGIST AND SOCIAL WORKER: Dr. William Hunt, Chicago, Illinois.

TOPIC C. EMPLOYEES ORGANIZATIONS AND UNIONS: Granville Hills, Albany, New York.

TOPIC D. EUGENIC PRACTICES IN HOSPITALS FOR THE MENTALLY ILL AND MENTALLY RETARDED: Dr. Gordon Allen, Bethesda, Md.

TOPIC E. THE PRESENT STATUS OF THE OPEN HOSPITAL: Dr. Christopher F. Terrence, Rochester, New York.

Fourth Day—Thursday, October 22

9:00 a.m. to 12 noon. Full Plenary Session: Main Group plus Pilot Groups. Selected leaders from the Pilot Group will present brief reports on their deliberations on THE PSYCHIATRIC PROBLEMS OF THE AGING AND OF THE AGING MENTAL DEFECTIVE. This will be followed by free discussion from the floor. Mid-morning break at 10:30 a.m.

12:00 Noon. Lunch for all members of the Institute.

1:00 p.m. Plenary Session: HOSPITAL PSYCHIATRY MEETS THE PRESS. A panel of well-known newspaper men will question a selected group of hospital psychiatrists on the general topic, "Are We Making Progress Against Mental Illness?"

2:00 p.m. "The Press—Help or Hindrance in Fighting Mental Illness?" The hospital psychiatrists will turn the tables and question the press on their responsibility in this field. The session will close with "Questions From the Floor" which may be addressed to any member of the two groups.

3:00 p.m. Close of Institute

M.H.S. Loan Library

The Mental Hospital Service Loan Library has been completely revised and many new manuals have been incorporated. At the same time some very old volumes have been withdrawn and letters have gone out requesting up-to-date replacements for them.

Under a new system of distribution, subscribers will no longer be required to pay postage to receive Loan Library material; only to return the volumes to the A.P.A.

A revised Loan Library List with new regulations is being sent out as a supplementary mailing to Mental Hospital Service subscribers this month. Several new categories of manuals have been added to the list and some of the former categories have been divided to better describe the material included.

It is anticipated that distribution of the new list will create a heavy demand, particularly for the latest editions in the library. Since only six copies of each manual are available, and not all subscribers observe the two-week limit on keeping Loan Library material, it is sometimes impossible to fill orders immediately upon receipt. However, the recent reorganization is expected to facilitate handling of requests and provide better service to all subscribers.

QUARTERLY HOSPITAL PROFESSIONAL CALENDAR

A.P.A. ANNUAL MEETING

1960 May 9-13, Convention Hall, Atlantic City
1961 May 7-12, Hotel Morrison, Chicago

A.P.A. MENTAL HOSPITAL INSTITUTE

1959 Oct. 19-22, Hotel Statler, Buffalo
Oct. 19, Special Sectional Meetings
Oct. 20-22, Plenary Sections
1960 Oct. 17-20, Hotel Utah, Salt Lake City
1961 Oct. 23-26, Hotel Fontenelle, Omaha

Other Meetings, May, June, July, 1959:

AMERICAN SOCIETY OF TRAINING DIRECTORS (Hospital Training Group), May 4-8, Detroit

NATIONAL LEAGUE FOR NURSING, May 11-15, Philadelphia

SOCIETY OF MEDICAL PSYCHOANALYSTS, May 13, N.Y.C.

AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, May 19-23, Milwaukee

CATHOLIC HOSPITAL ASSOCIATION, Annual Meeting, May 30-June 4, St. Louis

CANADIAN MENTAL HEALTH ASSOCIATION, Annual Meeting, June 2-4, Ottawa

AMERICAN GERIATRICS SOCIETY, Annual Meeting, June 4-5, Atlantic City

CANADIAN PSYCHIATRIC ASSOCIATION, Annual Meeting, June 5-6, Ottawa

AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY, Annual Meeting, June 11-14, Atlantic City

21ST CONGRESS OF THE INTERNATIONAL PSYCHOANALYTICAL ASSOCIATION, July 26-30, Copenhagen, Denmark

Commissioners to Attend Special Institute

A two-week Institute in Executive Development for Mental Hospital Administrators is being offered at the University of Chicago from May 10th through 22nd for a group of state commissioners of mental health. The Institute will be conducted at International House on the campus of the University. A second Institute is to be held in the fall for other psychiatric administrators.

These short Institutes are designed to broaden understanding of the administrative process for those who are responsible for the administration of mental hospital and state mental hospital systems. The Institutes will consist of seminars supplemented by lectures, case studies and special sessions. The objective of the course is to apply theoretical administrative material to practical situations with which the psychiatric administrator is likely to be confronted.

For details about cost, firm dates and possible vacancies for the fall Institute, contact Edward H. Van Ness, 64 East Lake Street, Chicago, Illinois.

PEOPLE & PLACES

CALIFORNIA: **Dr. G. W. Shannon** has resigned as associate superintendent of Patton State Hospital to take up her duties as psychiatrist at the California Institute for Women, Department of Corrections, at Corona. **Dr. Robert A. Kimmich,** formerly with the Illinois State Psychiatric Institute in Chicago, is now director of professional services at Stockton State Hospital.

KANSAS: Effective June 30, **Dr. William S. Simpson** will resign his job as clinical director of Topeka State Hospital to join the staff of the Menninger Foundation. He will be succeeded on July 1 by **Dr. George Welscher.**

Mr. Marvin E. Larson has been named executive secretary of the State Board of Social Welfare, a position left vacant in February by the death of **Mr. Frank Long.**

Dr. Edmond de St. Felix has returned to the staff of Larned State Hospital after completing 30 months of residency training at Topeka State Hospital to become board-eligible. He has assumed the position of clinical director, succeeding **Dr. Kedar Bhasker,** who had been acting clinical director since January 1, 1958. Dr. Bhasker has returned to Topeka State Hospital to complete his residency training.

HERE & THERE: **Dr. Harold William Conran,** formerly director of professional services of Kentucky Department of Mental Health, is the new superintendent of Western State Hospital, Hopkinsville, Ky.

Dr. William P. Hurder recently became associate director for mental health of the Southern Regional Education Board in Atlanta, Ga.

HAVE YOU HEARD?

COMMUNITY RELATIONS: An active group of 150 volunteers—the Women's Hospital Guild—is conducting a one-afternoon-a-week group social therapy class for patients at **Dayton (Ohio) State Hospital.** These sessions give the patients an opportunity to gain confidence, acquire poise and develop the lost art of conversation. Since social therapy started nine years ago, 847 women patients who attended the classes have gone home. They all agree that this form of therapy has helped them to get well.

PERSONNEL EDUCATION: The nightshift personnel at **Nebraska Psychiatric Institute, Omaha,** now have an opportunity of knowing what goes on in the hospital during the day through the help of recordings. Tapes are made of ward conferences, nurse-resident meetings, head nurse meetings, and nurse inservice education meetings. The eleven-to-seven staff can in this manner get a better understanding of the patients, with whom they have but few contacts, and be kept informed of new programs and developments. This innovation was accepted enthusiastically by the night personnel whose interest in their work is thus greatly stimulated.

PATIENTS' ACTIVITIES: Last sum-

mer a group of patients—the Female Farm Group—of **Norristown (Pa.) State Hospital** put in many hours of backbreaking labor harvesting vegetables on the institution's farm. They picked over a quarter of a million pounds of vegetables, husked and silked close to 175,000 pounds of sweet corn, assisted in the preparation and freezing of vegetables for the hospital's consumption. Harvesting of last year's bumper crop could not have been done in time without the help of these patients, many of whom have volunteered for the job this summer.

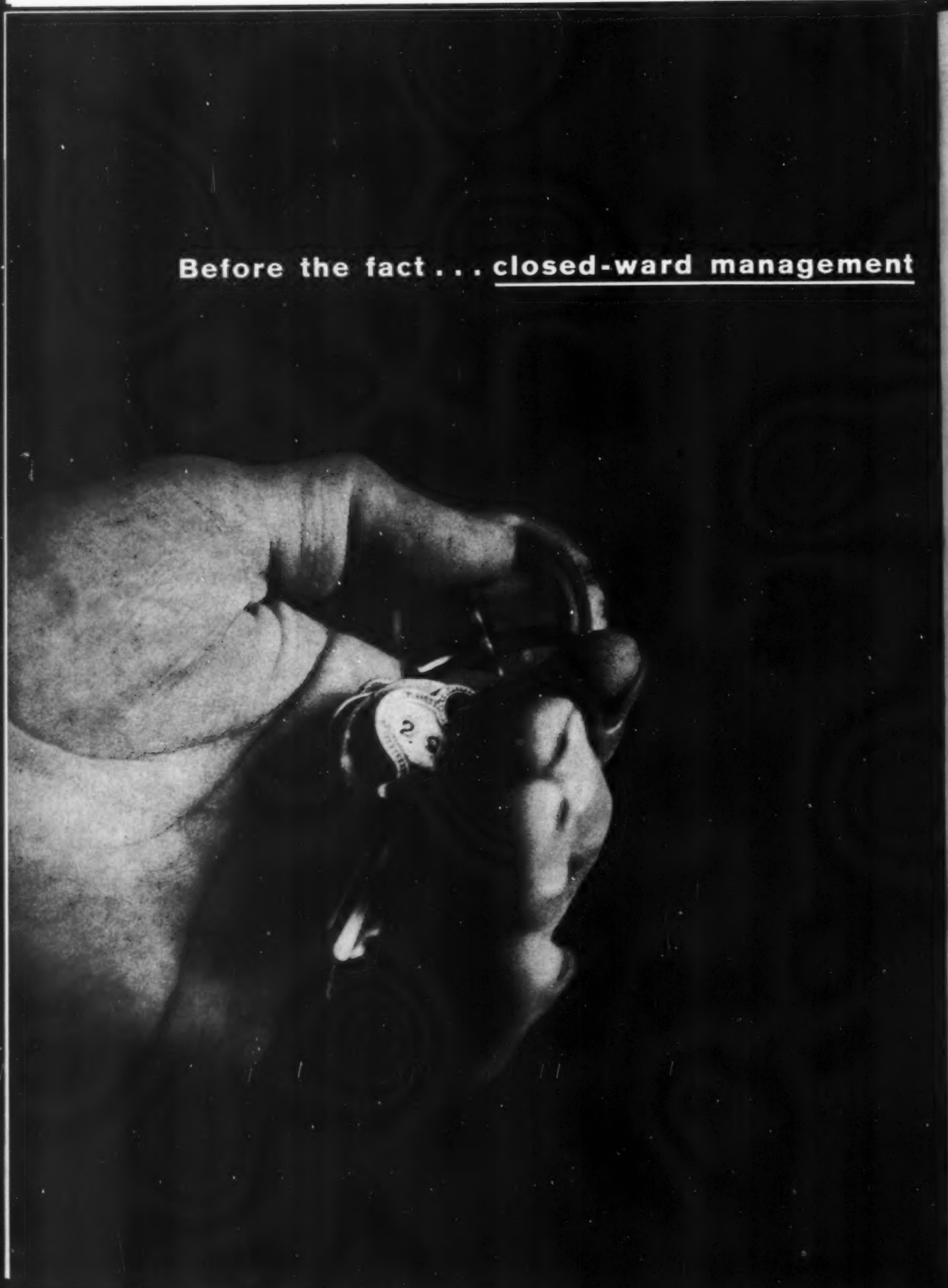
PATIENTS' OPINIONS: At **Central State Hospital, Lakeland, Ky.**, 72 patients were interviewed just prior to their discharge. The majority of them were aware of why they were hospitalized and why they needed to come to the hospital when they did. They were asked to mention what they liked and disliked most about their stay at the hospital. Eighty-six per cent had favorable comments about the institution. Among the things they liked best were the work assignments, RT and OT, and the interest shown them by medical and nursing personnel. They disliked the food, the confinement, the crowding, and being around other sick patients at the time when they themselves were recovering. Half of the patients interviewed said they were helped the most by drugs, 16 by electroshock therapy, and 15 by a combination of both. Only half of them worried about having to be readmitted.

CANADA: Ontario's Minister of Health has initiated a program of mental health services which, says Dr. J. D. Griffin, will be the envy of all Canada when it is fulfilled. The program reflects the following fundamentals: (1) the principle of regional services for diagnosis, day and night care, short-term inpatient treatment; (2) adoption of the small (250-300 beds) hospital concept; (3) elimination of "certification" of patients wherever possible; (4) providing facilities for remotivating patients for normal living; (5) new architectural designs better adapted to therapeutic objectives; (6) energetic recruitment and better training opportunities, including general practitioners; and (7) active research.

APPROPRIATIONS, GRANTS & LOANS: In **Indiana**, the State House of Representatives allocated an *additional* $3 million to aid the mentally ill, at the same time it was in the process of slashing $21 million off the budgets of the various other governmental departments.

The **National Institute of Mental Health** allocated during the month of January over $870,000 for 59 new research grants and some $30,000 for 9 new full-time fellowships.

Loans are now being made by the **Small Business Administration** of the U. S. Department of Commerce for the development of small businesses (capital of less than $1 million) for, among other projects, the building of private medical facilities, such as hospitals, clinics and nursing homes, rehabilitation and convalescence centers. These loans differ from mortgages in that they can be used as equity capital. They are generally limited to a sum which matches the amount raised by the investors, but not in excess of $300,000.


Before the fact . . . closed-ward management

MARKED IMPROVEMENT WITH 'Deprol'

REPORTED IN THREE PSYCHIATRIC STUDIES

	STUDY #1	STUDY #2	STUDY #3
NUMBER OF PATIENTS	135	35	52
TYPE OF PATIENTS	Depressed, chronic psychotic patients, mostly schizophrenic (hospitalized)	26 psychotic depressions, manic-depressive and involutional; 9 neurotic depressions (private practice).	36 involutional depressions, av. age 77 (custodial patients in nursing home); 16 reactive depressions, av. age 65 (private practice).
DOSAGE	1-4 tabs. q.i.d. (av. 2 tabs. q.i.d.)	1-3 tabs. q.i.d.	1-2 tabs. t.i.d. or q.i.d.
DURATION OF TREATMENT	1 wk.-17 mos., (av. 1.8 mos.)	1-25 wks. (av. 8 wks.)	6-22 wks.
RESULTS	Substantial improvement in 41%; some improvement in an additional 39%.[1]	Complete or social recovery in 57%.[2]	Good results in 78% of involutional depressions and in 69% of reactive depressions.[3]

ADVANTAGES OF 'Deprol'

- Antidepressant action does not produce excessive stimulation, jitters, insomnia
- Restores normal sleep without depression-producing aftereffects
- Improves mood without depressing appetite

DOCUMENTED SAFETY[1-4]

- Deprol has not produced hypotension or liver toxicity
- Does not interfere with other drug therapies, or with sexual function
- Can be used in hypertension, and with unstable personalities
- Side effects are minimal

Composition: Each light-pink, scored tablet contains 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

References:
1. Pennington, V.M.: The use of Deprol in chronic psychotic patients. Am. J. Psychiat. 115:250, Sept. 1958. **2.** Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **3.** Settel, E.: Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Submitted for publication, 1958. **4.** Personal communications from physicians; in the files of Wallace Laboratories.

WALLACE LABORATORIES
New Brunswick, N. J.

CD-9680 †TRADE-MARK

RATED FIRST
FOR TRANQUILIZING EFFECT[1]

IN HOSPITALIZED PSYCHIATRIC PATIENTS, Miltown has demonstrated great usefulness in relieving anxiety and tension.[1-5]

In tranquilizing effect Miltown has been found superior to phenothiazine derivatives and Rauwolfia products.[1] However, its anti-psychotic effect is less pronounced than that of the other drugs.[1]

On the other hand, combined with an effective anti-psychotic preparation, Miltown becomes "extremely valuable in alleviating the overactivity, tension, excitement and anxiety of the psychotic."[1]

An added advantage of Miltown is relaxation of skeletal muscle, not obtained with most other tranquilizers.

References: 1. Barsa, J. A.: Am. J. Psychiat. 115:79, July 1958. 2. Graffagnino, P. N., Friel, P. B. and Zeller, W. W.: Connecticut M. J. 21:1047, Dec. 1957. 3. Hollister, L. E., Elkins, H., Hiler, E. G. and St. Pierre, R.: Ann. New York Acad. Sc. 67:789, May 9, 1957. 4. Pennington, V. M.: Am. J. Psychiat. 114:257, Sept. 1957. 5. Tucker, K. and Wilensky, H.: Am. J. Psychiat. 113:698, Feb. 1957.

Available in 400 mg. scored and 200 mg. sugar-coated tablets. Also available as MEPROSPAN* (200 mg. meprobamate *continuous release* capsules). *TRADE-MARK

Miltown®
meprobamate (Wallace)

CM-7881

WALLACE LABORATORIES,
New Brunswick, N. J.